

069384 OCT 22 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DAVID VERNON IRVIN			2a. DATE OF DEATH MONTH OCT DAY 13 YEAR 1987			2b. HOUR 6:30 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH Aug DAY 12 YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH PARKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2298-C LOWELL RIDGE RD. 21234				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAPER DELIVERY		12b. KIND OF BUSINESS OR INDUSTRY SALT. SUN	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN PARKVILLE									
14. FATHER'S NAME FIRST LAURENCE MIDDLE IRVIN LAST 			15. MOTHER'S MAIDEN NAME FIRST MARY CAROLINE MIDDLE STANS LAST 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-07-7415			17. INFORMANT FAMILY RECORDS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma involving liver DUE TO, OR AS A CONSEQUENCE OF (b) liver failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 10/7 19 87 to 10/13 19 87 , that (1) (we) last saw the deceased alive on 10/10 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) did not view the body after death.							
22b. SIGNATURE [Signature]				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. NICHOLAS J. BELTAS				22e. ADDRESS 206 E. EAGERS ST. BALT. MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 16, 1987		23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S LUTHERAN CHURCH		23d. LOCATION CITY OR TOWN PARKVILLE COUNTY BALT. STATE MD.	
24. FUNERAL DIRECTOR NAME EMMA'S CHAPEL OF MEMORIES ADDRESS 8800 HARFORD RD. 21234				25a. DATE REC'D. BY REGISTRAR OCT 21 1987 25b. REGISTRAR'S SIGNATURE Julia D. [Signature]			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

Page 4 may be retained by the hospital or attending physician.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. All other pages should be removed. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 28 shows only injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		REG. NO.		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		OCTOBER		28, 1987		7:15A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
M		W		MONTH 5 DAY 5 YEAR 35		52 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MD.		U.S.A.				baltimore county						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		CHURCH HOSPITAL		LONGSHOREMAN									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
MD.		BALTIMORE		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3409 WALLFORD ST. 21222					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
FRANCIS JACKSON		LOUISE FADER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
YES		213-32-9400		DELORES JACKSON - wife - s/a									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) PNEUMONIA, SEPSIS													
DUE TO, OR AS A CONSEQUENCE OF													
(b) CANCER OF THE LUNG													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK													
22a. I certify that (I) this hospital attended the deceased from OCTOBER 27, 19 87, to OCTOBER 28, 19 87, that (I) (we) lost saw the deceased alive on OCTOBER 28, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
BEENA NAG PAL													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
BEENA NAG PAL M. D.				CHURCH HOSPITAL CORP. 100 N. BROADWAY BALTIMORE, MD. 21231									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal				10-28-87									
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
State Anatomy Board				Balto., Md.				NOV 02 1987				Julia Davidson-Pandora	

RECEIVED BY THE DIRECTOR
JAN 10 1951

01577 NOV 10 51



068210 OCT-9-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Minnie Louise Jackson			2a. DATE OF DEATH MONTH DAY YEAR Oct. 4, 1987		2b. HOUR 8:50p M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1910	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Harold Swift	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Walker		16. STREET ADDRESS / ZIP CODE 6208 Fair Oaks Ave. 21214		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-12-8916A	17. INFORMANT Marguerite Lee, 6207 Fair Oaks Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CARDIO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>VASCULAR DISEASE</u>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DEMENTIA</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (EAT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>11-19</u> , 19 <u>86</u> , to <u>10-04</u> , 19 <u>87</u> , that (I) (we) lost <u>lost</u> the deceased alive on <u>10-03</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) send the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/5/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS RIVERA MD		22e. ADDRESS 5914 Harford Rd. BALTO MD 21214			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 7, 1987	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION CITY OR TOWN COUNTY STATE Overlea, Balto/. Md.		
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214			25. DATE REC'D. BY REGISTRAR OCT 08 1987		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be examined by a physician within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

16 9-129 01 2830

069367 OCT 22 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosalie JACKSON			2a. DATE OF DEATH MONTH DAY YEAR October 15, 1987		2b. HOUR 5:55p M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 2, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2 Slipstream Ct. 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Anton Wilde				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Bichsel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 217-18-6926		17. INFORMANT ADDRESS Steve Jackson 1045 Ensor Drive 21085			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal bleeding, Cardiopulmonary arrest. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) Liver Failure, Right lung pneumonia. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Kidney failure.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 10, 1987 to October 15, 1987 , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on October 15, 1987 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE R.A. Richards MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-15-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.A. Richards MD			22e. ADDRESS 9000 Franklin Square Drive, Balto., 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/19/87		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Balto. Maryland		
24. FUNERAL DIRECTOR Connelly Funeral Home 300 Mace Ave. 21221					25a. DATE REC'D. BY REGISTRAR OCT 21 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 22 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

0 6 3 2 0 0 1 3 3 0 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
2a. DECEASED NAME (TYPE OR PRINT) John E. Jaworski					2b. DATE OF DEATH MONTH DAY YEAR Oct. 29 87					
3 SEX Male					4 RACE Caucasian					
5 DATE OF BIRTH MONTH DAY YEAR June 14 1894					6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland					7b. CITIZEN OF WHAT COUNTRY? USA					
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9 BALTIMORE CITY OR COUNTY OF DEATH Balto. County MD.					
10 CITY OR TOWN OF DEATH Baltimore					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8128 Bradshaw Road					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Care-taker					12b. KIND OF BUSINESS OR INDUSTRY School or Cemetery					
13a. STATE Md.					13b. CITY OR TOWN Bradshaw					
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13d. STREET ADDRESS 8128 Bradshaw Road					
14 FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 213-01-5272					
17 INFORMANT Ferdinand Jaworski					ADDRESS same address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer Stomach										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Jan 19 87			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I (this hospital) attended the deceased from Jan 19 87 to Oct. 19 87 , that (I) (we) last saw the deceased alive on 10-19 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) view the body after death.										
22b. SIGNATURE William A. Tyson M.D.						DEGREE		22c. DATE SIGNED 10-29-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. A. Tyson						22e. ADDRESS Box 158 Kingsville Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-2-87			23c. NAME OF CEMETERY OR CREMATORY St. Stephen's Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Bradshaw, Md.	
24. FUNERAL HOME, INC. Schumanek Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR OCT 30 1987		25b. REGISTRAR'S SIGNATURE John A. Anderson		
24. ADDRESS 9705 Belair Road, Balto., Md. 21236										

02-0210 NOV-507

31158-54

Time 14.18.22

069738 OCT 26 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Felix Frank JAWORSKY			2a. DATE OF DEATH MONTH DAY YEAR October 22, 1987		2b. HOUR 12:13P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb 17, 1905	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Railroad
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Linover	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Felix Jaworsky			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Kraus		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 705-10-0028	17. INFORMANT ADDRESS Patricia Cain 306 Songwood Ct Millersville, MD 21108		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Ischemia with</u> DUE TO, OR AS A CONSEQUENCE OF <u>Ventricular Tachycardia and Fibrillation</u> (b) <u>Severe Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>Severe Chronic Obstructive Pulmonary Disease & Asthmatic Bronchitis</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.					
19a. DATE OF OPERATION /		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED /		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOWHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 20</u> 19 <u>87</u> , to <u>Oct</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Oct 16</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Frank T. Kasik, Jr.</u>			DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Oct 23, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank T. Kasik, Jr. M.D.			22e. ADDRESS 9005 Harford Road Baltimore, MD 21234		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 26, 87		23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens Belair, Harford Co., MD.	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME DIPPEL FUNERAL HOME, INC. 7110 Belair Road Baltimore, MD 21206			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE OCT 23 1987 <u>Julia...</u>			

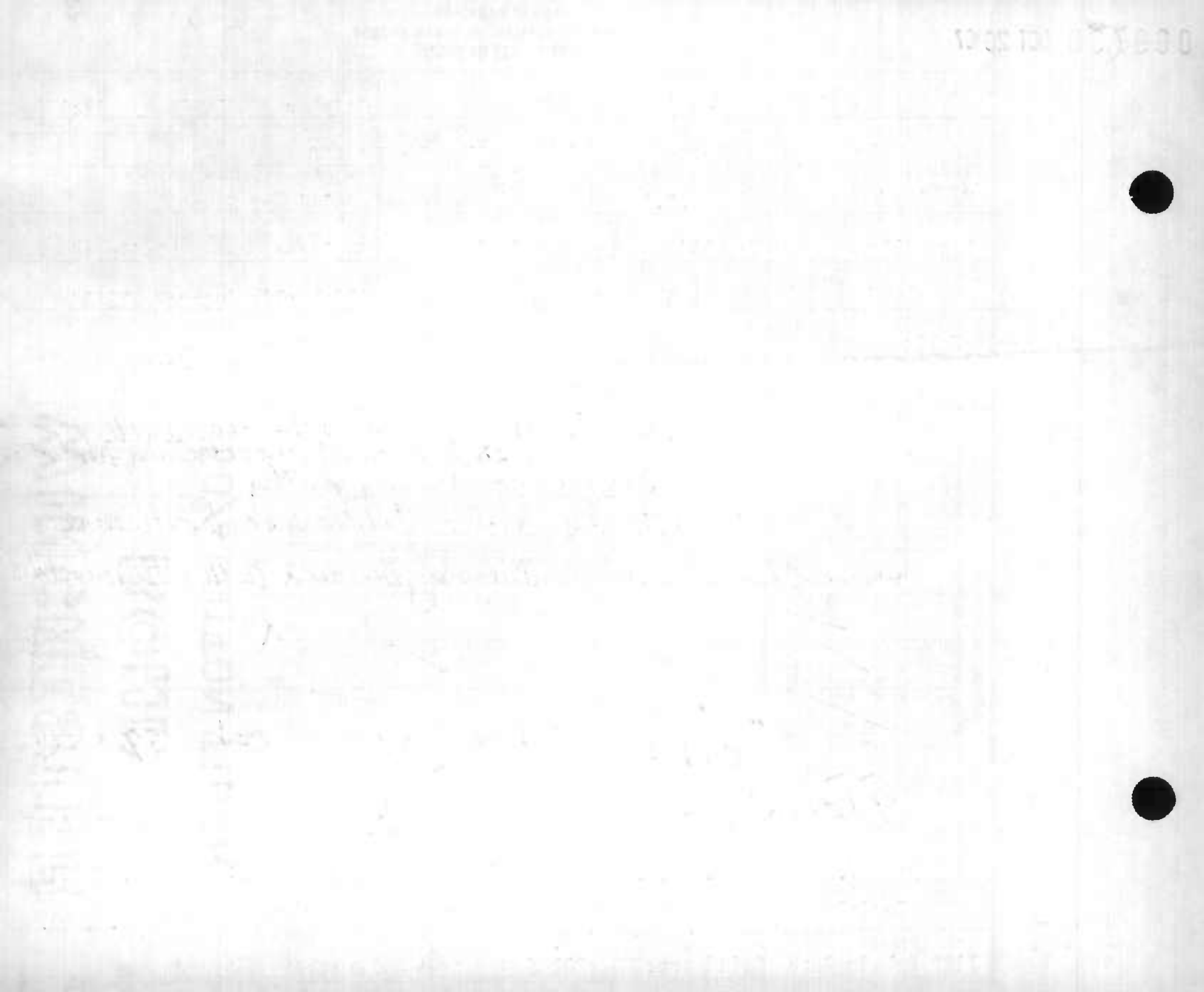
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP
DHMH - 16 50M 1/BI
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

LEO

JEANNETTA

2a DATE OF DEATH

MONTH

DAY

YEAR

2b HOUR

10-9-87

11:25 AM

3. SEX

MALE

4. RACE

CAU.

5. DATE OF BIRTH

8 6 11

6. AGE (IN YEARS LAST BIRTHDAY)

76

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

MD.

7b CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTO. County MD.

10. CITY OR TOWN OF DEATH

Towson

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

STELLA MARIS HOSPICE

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Plumber

12b KIND OF BUSINESS OR INDUSTRY

Plumbing

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MD.

13b COUNTY

BALTO

13c CITY OR TOWN

13d INSIDE CITY LIMITS?

YES ☐ NO ☐

13e STREET ADDRESS, ZIP CODE

117 S. Central Ave

14. FATHER'S NAME

SAVERIO

MIDDLE

JEANNETTA

15. MOTHER'S MAIDEN NAME

PAULOMINA

MIDDLE

ORANGE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b SOCIAL SECURITY NO.

217-09-2982

17. INFORMANT

ADDRESS

Rockville GROWSKOWSKI 4415 Raspe Ave

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CANCER Lung-mixed cell

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) this hospital attended the deceased from 10-2, 19 87, to 10-9, 19 87, that (1) (we) last saw the deceased alive on 10-9, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.

22b. SIGNATURE

Carla S. Alexander

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

16-9-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Carla S. Alexander, M.D.

22e. ADDRESS

Stella Maris Hospice

Dulaney Valley Rd. - Towson, MD 21204

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

10/12/87

23c. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

23d. LOCATION

BALTO

COUNTY

MD.

STATE

24. FUNERAL DIRECTOR

Frank Dillman

ADDRESS

322 S. High St

25a. DATE REC'D. BY REGISTRAR

OCT 15 1987

25b. REGISTRAR'S SIGNATURE

Carla S. Alexander-Rodell

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 11th inst. in relation to the above matter.
I am sorry to hear that you are not satisfied with the results of the examination.
I will be glad to have you call on me at my office, and we will discuss the matter in detail.
Very respectfully,
J. H. [Name]

Yours truly,
J. H. [Name]
[Address]
[City, State]

070295 OCT 30 1987

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 7 2 8 1 1 5	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (PRINT) Mildred (NMN) JEROSIMICH					2a. DATE OF DEATH MONTH DAY YEAR October 27, 1987			2b. HOUR 4:10p M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 21, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Yugoslavia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD					
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY A A Co.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8400 Echo Drive 21122			
14. FATHER'S NAME FIRST MIDDLE LAST Richard Pajic				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angelina (UNKNOWN)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA		17. INFORMANT (Daughter) Mary Kurilich		ADDRESS Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DUE TO, OR AS A CONSEQUENCE OF (b) End stage heart failure. </div> <div style="width: 45%;"> DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy. </div> </div>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from October 20, 1987 to October 27, 1987 that (we) last saw the deceased alive on October 27, 1987, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jeanne Liao, M.D.					DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeanne Liao, M.D.					22e. ADDRESS 9000 Franklin Square Drive, Balto., 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct 30, 1987		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Maryland			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home					ADDRESS Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 29 1987		25b. REGISTRAR'S SIGNATURE Julia Denton-Randall		

2070

069737 OCT 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST					MONTH DAY YEAR					MONTH DAY YEAR	
Elinor Rogers Johnson					October 21, 1987					4 a.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
F		W		MONTH DAY YEAR		61 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA				Baltimore Co., MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		1311 Glenmont Road				Social Worker		Balto., Co.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
13a. STATE					YES <input type="checkbox"/> NO <input type="checkbox"/>		1311 Glenmont Road 21239				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST					FIRST MIDDLE LAST						
Lloyd Russell Rogers					Elsie Kuldell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					220 18 6871		Mr. Edward L. R. Johnson 3012 N. Calvert St. 21218				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>prostate cancer</u>										3 years	
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>pancreas</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>causes</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>10/84</u> 19 <u>84</u> , to <u>10/21</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>10/20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>Bruce Rosenberg MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				10/22/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
BRUCE ROSENBERG				1134 YORK RD LUTHERVILLE MD 21093							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial			10/23/87		Woodlawn Cemetery			CITY OR TOWN COUNTY STATE			
								Baltimore, Md.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE					
MITCHELL-WIEDEFELD HOME, INC.						OCT 23 1987 Julia Davidson-Rose					

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OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA GEN. REG. NO. 27

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				87 28117			
87. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Willie (William) Ira Johnson				MONTH DAY YEAR October 21, 1987			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Male		White		MONTH DAY YEAR March 7, 1906		71. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Halifax Co., Va.		U.S.A.				Baltimore County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Dundalk		2905 Dunmore Road		Police Officer		Steel Mfr.	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Balto.		Dundalk	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Robert Johnson				FIRST MIDDLE LAST Daisy Gertrude Royster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes				217.14.5928		Margaret Y. Johnson (Wife) (Same as 11)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ELECTRO MECHANICAL DISSOCIATION							
DUE TO, OR AS A CONSEQUENCE OF (c) SKELETAL ARTERIOVASCULAR CORONARY DISEASE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22c. ADDRESS		22c. DATE SIGNED	
J M NIEMOFF, MD				9000 FRANKLIN SQUARE DRIVE BALTO, MD 21237		10/21/1987	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		10/24/1987		Green Mount Crematory		Baltimore Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Walter Brooks Bradley Inc. Dundalk Md, 21222				OCT 27 1987		Julia Davidson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (PRINT) FIRST MIDDLE LAST ROBERT L JONES			2a. DATE OF DEATH MONTH DAY YEAR 10 25 87		2b. HOUR 2:08 P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 04 26 22	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
12. CITY OR TOWN OF DEATH TOWSON	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL		14. USUAL OCCUPATION (GIVE WORK OR MOST OF WORKING LIFE) PAPER CUTTER	15. KIND OF BUSINESS OR INDUSTRY PRINTING	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD 16b. COUNTY BALTIMORE 16c. CITY OR TOWN BALTIMORE			17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
18. STREET ADDRESS / ZIP CODE 4 ECHOWAY CT APT 2C 21204			19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED C. JAMES		
20. FATHER'S NAME FIRST MIDDLE LAST LAWRENCE L. JONES			21. ADDRESS MARY JONES 4 ECHO WAY CT. 21204		
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			23. SOCIAL SECURITY NO. W.W. II 214-16-8644		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerotic cardiovascular disease</u> - years (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Hypertension</u>					
25. MEDICAL CERTIFICATION 19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 21a. INJURY OCCURRED (WALKING <input type="checkbox"/> NOT WALKING <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/> 21b. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE 22. I certify that (I) (this hospital) attended the deceased from <u>10/19/87</u> to <u>10/25/87</u> that (I) (we) last saw the deceased alive on <u>10/19/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. <u>Deceased was dead in District Street St. Joseph's Hospital</u> 23. SIGNATURE <u>Gerald N. Maggid</u> DEGREE _____ 24. DATE SIGNED _____ 25. PHYSICIAN'S NAME (TYPE OR PRINT) GERALD N., MAGGID, M.D. 26. ADDRESS 8100 HARFORD RD. 665-4400 27. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 28. DATE OCT. 28, '87 29. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY 30. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND 31. FUNERAL DIRECTOR WILLIAM E. JOHNSON 32. DATE REC'D. BY REGISTRAR OCT 26 1987 33. REGISTRAR'S SIGNATURE <u>Julia [Signature]</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please indicate on the back of this certificate the date and time of burial, and the name of the funeral home to which the body is being taken. This certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked "B" shows any injury, or other traumatic event, the medical examiner must be notified at once.

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR							
-387 WILLIAM A. JONES								10 27 19 87								M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
Male		Black		4 7 52		35 YRS.						10 27 19 87								8P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Kentucky				U.S.A.								Baltimore County MD											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Rossville				Franklin Square Hospital				Mechanic															
13a. STATE								13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland								Harford		Havre de Grace		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2113 Williams Drive 21078									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
Perry Thomas Jones				Fanny Lee Ecton																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
No				216-56-3789				Perry T. Jones, father				Same as above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART 1 DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) Multiple injuries																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY?					
																		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 7 P.M. 10-27-19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
								Pedestrian struck by motor vehicle.															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Eastern Blvd. east of, Essex, Baltimore, MD Lyndbrook Rd.															
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy Chief				MEDICAL EXAMINER				DATE SIGNED 10-28-87											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/31/87				23c. NAME OF CEMETERY OR CREMATORY St. James United Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace, Harford, Md.											
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399								NOV 2 1987				[Signature]											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN JOYCE		2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 19, 1987		2b. HOUR P M 1 P	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 17, 1900	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH'S HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Utility Co.			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Joyce		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kearney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 321 10 7629A		17. INFORMANT ADDRESS Mr. Patrick V. Joyce 705 Kingston Rd. -12	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multi-Infarct Dementia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Severe ASUD - old Age DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/11/87 to 10/19/87 , that (I) (we) last saw the deceased alive on 10/19/87 , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bayou K. Zoroff, MD		DEGREE MD		22c. DATE SIGNED 10/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOYCE, JOHN		22e. ADDRESS 120 Sister Pierre Dr. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/23/87		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.	
				23d. LOCATION CITY OR TOWN COUNTY STATE River Grove, Ill.	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.				25a. DATE REC'D. BY REGISTRAR OCT 23 1987	
				25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows an injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Frank KACZOROWSKI KACZOR		2a. DATE OF DEATH MONTH DAY YEAR October 21, 1987		2b. HOUR 3:00a M	
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 08 25 1894		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY
13. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS, ZIP CODE 422 J. CHAPEL ST. 21231
14. FATHER'S NAME FIRST MIDDLE LAST VALENTINE KACZOROWSKI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MICHALINA PIECHOCKA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-07-5624		17. INFORMANT ADDRESS MR. RAYMOND KACZOROWSKI 2525 Fleet St 21224	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Sepsis, pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c) Adult respiratory distress syndrome

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from October 10, 1987, to October 21, 1987, that (we) last saw the deceased alive on October 21, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE T. KACZOROWSKI		DEGREE		22c. DATE SIGNED 10/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. KACZOROWSKI		22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10-23-87	23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD
24. FUNERAL DIRECTOR NAME KACZOROWSKI FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR OCT 22 1987	25b. REGISTRAR'S SIGNATURE via Gordon R. Rader

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INFORMATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is lawfully filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (PRINT)			2a. DATE OF DEATH		2b. HOUR	
3. SEX			4. RACE		5. DATE OF BIRTH	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.			17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/22</u> , 19 <u>85</u> , to <u>10/24</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>10/24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		

Leonard J. Ruck, Inc. 5305 Harford Road

OCT 28 1987

Aria T. Ruck

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE LEA KAPLAN			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 2 1987		2b. HOUR 4:30 A
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 8 1904	6. AGE (IN YEARS LAST BIRTHDAY) 83	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH PILLESVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3300 LEE CT.		12. KIND OF BUSINESS OR INDUSTRY CLOTHES		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) 13a. STATE N.Y.		13b. CITY OR TOWN BROOKLYN	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 2928 W. 5th ST. 21224	
14. FATHER'S NAME SOLOMON		15. MOTHER'S MAIDEN NAME BESSIE WAGNER		16. SOCIAL SECURITY NO. 055-01-9448	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		17b. SOCIAL SECURITY NO. 055-01-9448		17c. STREET ADDRESS / ZIP CODE 3300 BROOKLYN, N.Y. 11230	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal carcinoma with metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/13 19 87 to 10/2 19 87, that (I) (we) last saw the deceased alive on 9/30 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.					
22b. SIGNATURE H. Ronald Friedman		DEGREE MD		22c. DATE SIGNED 10/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Ronald Friedman		22e. ADDRESS 6715 Park Heights Ave. 21201			
23a. BURIAL, CREMATION, REMOVAL REMOVAL/BURIAL		23b. DATE OCT. 4, 1987	23c. NAME OF CEMETERY OR CREMATORY NEW MONTEFIORE		23d. LOCATION PINE LAWN, L.I., NEW YORK
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR OCT - 6 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070226 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William M. KAPPEL			2a. DATE OF DEATH MONTH DAY YEAR October 24, 1987		2b. HOUR 10:35pm
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville 21237	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITIES, GIVE STREET ADDRESS) Franklin Sq. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY Balto. Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Essex			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 310 Lorraine Ave. 21221	
14. FATHER'S NAME FIRST MIDDLE LAST George Kappel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Lowman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 01 6072		17. INFORMANT ADDRESS Erma Lader 6826 Gough St. Balto 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease, Myocardial Infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Cronic Obstructive Pulmonary Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 24, 1987 to October 24, 1987 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 24, 1987 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE <i>Naeen Gauhar</i>				22c. DATE SIGNED 10/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Naeen Gauhar, M.D.				22e. ADDRESS 9000 Franklin Square Drive, 21237	
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 10/28/87		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		24. FUNERAL DIRECTOR Boudzinski Funeral Home PA 1407 Old Eastern Ave. 21221			
25a. DATE REC'D. BY REGISTRAR OCT 27 1987		25b. REGISTRAR'S SIGNATURE <i>John Darden-Randall</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified by page 3.

070105 OCT 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES W. KEATTS IV			2a. DATE OF DEATH MONTH 10 DAY 17 YEAR 87			2b. HOUR 0031 M	
3. SEX M.		4. RACE W		5. DATE OF BIRTH MONTH 12 DAY 24 YEAR 56		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Ceneral		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office mgr.		12b. KIND OF BUSINESS OR INDUSTRY Auto	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus	
14. FATHER'S NAME FIRST James MIDDLE W. LAST Keatts III				15. MOTHER'S MAIDEN NAME FIRST Grace MIDDLE E. LAST Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) na		17. INFORMANT ADDRESS James W. Keatts III, 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADULT RESPIRATORY DISTRESS SYNDROME 912 DUE TO, OR AS A CONSEQUENCE OF (b) DIFFUSE ASPILATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from October 9 , 19 87 , to October 17 , 19 87 , that (I) (we) last saw the deceased alive on October 16 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Howard Jacobs, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD JACOBS, MD		22e. ADDRESS 70 D Painter's Mill Rd Owings Mill Md. 21117					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/21/87		23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		23d. LOCATION CITY OR TOWN Baltimore COUNTY Howard STATE Md.	
24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminster, MD ADDRESS 412 Washington Road				25a. DATE REC'D. BY REGISTRAR OCT 26 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070105 0100

4-1-10

DEPT. OF JUSTICE

ATTORNEY GENERAL

MEMORANDUM

TO :

FROM :

SUBJECT :

CLASS :

071585 NOV 12 1987

Items 18a, 20, 21a, b, c, d, e, f, 22a, dw STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20. DATE KNOWN OF DEATH ESTIMATED ☒ MONTH DAY YEAR 10 27 19 87
 21. DATE PRONOUNCED DEAD 10 27 19 87
 22. HOUR 12:30 A.M.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY M. KEIGLER
 2. SEX F 3. RACE W 4. DATE OF BIRTH MONTH DAY YEAR 4 29 09 5. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. 6. IF UNDER 1 YR. MONTHS DAYS 7. IF UNDER 24 HRS. HOURS MIN.
 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.
 10. CITY OR TOWN OF DEATH Towson 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY 12b. KIND OF BUSINESS OR INDUSTRY INS. COMP.
 13a. STATE MD. 13b. CITY BALTIMORE 13c. CITY OR TOWN TOWSON 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS 1105 IVY WOOD RD. 21204
 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM KEIGLER 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HEER
 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 213-05-4919 17. INFORMANT ADDRESS JOHN MAHLEY - EXECUTOR 539-3816

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Phenobarbital intoxication
 DUE TO, OR AS A CONSEQUENCE OF
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
 (b) DUE TO, OR AS A CONSEQUENCE OF
 (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐
 21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 Subject took drugs
 21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK ☒ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1105 Ivywood Rd. Baltimore County, MD.
 22a. I certify that I took charge of the remains described above. Held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural Causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒.
 ACTUAL SIGNATURE Charles P. Kokes, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-27-87
 EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal 23b. DATE 11-6-87 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE
 24. FUNERAL DIRECTOR NAME ADDRESS State Anatomy Board Balto., Md. 25a. DATE REC'D. BY REGISTRAR NOV 10 1987 25b. REGISTRAR'S SIGNATURE Julia Sanders-Pandora

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM TM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

051282 MAY 15 61



069759

OCT 25 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

PAUL

Cole

KELBAUGH

2a. DATE OF DEATH MONTH DAY YEAR 10 20 '87 2b. HOUR 8:47 P M

3. SEX

MALE

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR 05 08 '21

6. AGE (IN YEARS LAST BIRTHDAY)

66

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE COUNTY

MD.

10. CITY OR TOWN OF DEATH

TOWSON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

GEMC-6701 N. CHARLES ST.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Fork Lift Oper.

12b. KIND OF BUSINESS OR INDUSTRY

Black & Decker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Balto.

13c. CITY OR TOWN

Cockeysville

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

1421 Shawan Rd. 21030

14. FATHER'S NAME

Harry

MIDDLE

Richard

LAST

Kelbaugh

15. MOTHER'S MAIDEN NAME

Bertha

MIDDLE

Garphelia

LAST

Cole

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

219-18-8180

17. INFORMANT

Margaret R. Kelbaugh, 1421 Shawan Rd.

ADDRESS Cockeysville 21030

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

± 10 YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

DIABETES

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from July 19 79, to 10/20 19 87, that (I) (we) lost
saw the deceased alive on 10/12 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Edward P. Costlow

DEGREE

MD

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

10 21 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Edward P. Costlow, M.D.

22e. ADDRESS

10 Gerard Ave. Room 214

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)
Burial

23b. DATE

10/24/87

23c. NAME OF CEMETERY OR CREMATORY

Mt. Carmel Cemetery

23d. LOCATION

Parkton

COUNTY STATE

Maryland

24. FUNERAL DIRECTOR

J. E. Lowell Lemmon, 10 W. Padonia RD.

25. DATE REC'D. BY REGISTRAR

OCT 23 1987

25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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069160 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gladys Lucinda KELLER			2a. DATE OF DEATH MONTH DAY YEAR October 8, 1987		2b. HOUR 8:50a M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 24 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE West Virginia			13b. COUNTY Berkeley	13c. CITY OR TOWN Martinsburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Taylor R. Hardy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma F. Fitzpatrick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-18-2510		17. INFORMANT ADDRESS Nancy Caperna 8026 Eastdale Rd. Baltimore, MD 21224	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Lung abscess

DUE TO, OR AS A CONSEQUENCE OF

(c) Pneumonia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Chronic obstructive pulmonary disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from September 12, 1987, to October 8, 1987, that (I) (we) lost saw the deceased alive on October 8, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard Goldman, MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Goldman, M.D.		22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 10/9/87	23c. NAME OF CEMETERY OR CREMATORY Smithsburg Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Smithsburg Washington MD
24. FUNERAL DIRECTOR Charles M. Brown		25. DATE REC'D. BY REGISTRAR OCT 13 1987	
327 W. King St. Brown Funeral Home PO Box 821, Martinsburg, WV		REGISTRAR'S SIGNATURE Julia Darden-Ludlow	

1305130 001280

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
		EDITH		A.		KELLY	10-23-87		1:50 p.m.
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
FEMALE		W		3 3 1902		85 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Jamaica		USA				Baltimore County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		ST. JOSEPH HOSPITAL				Director		American Cancer Society	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		BALTIMORE		TOWSON				7700 OAKLEY RD. 21234	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Colin Reid Campbell				Anne MacKenzie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		212-16-2362		7700 Oakley Rd. Miss Madeline Fitzgerald Balto., Md. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intercerebral hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension & atrial fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE						22c. DATE SIGNED			
<i>Natividad D. de Leon, M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						10/23/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
NATIVIDAD D. DE LEON						c/o ST. JOSEPH HOSPITAL, TOWSON, MD. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		10/24/87		Greenmount		Baltimore City, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212						OCT 29 1987		<i>Lia Davidson-Randall</i>	

100-111-62070

069674 OCT 26 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lucille A. Kerner			2a. DATE OF DEATH MONTH DAY YEAR October 20 1987		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 30 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.VA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Essex	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1032 Middlesex Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY Balto.	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Roy Norman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Jackson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-30-8523		17. INFORMANT ADDRESS Edward Kerner 1032 Middlesex Rd. 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Cancer</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Maria Diaz, MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-21-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maria Diaz, MD		22e. ADDRESS 413 Eastern Ave. Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/23/87		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Middle River Balto. Maryland		23e. DATE OF DEATH OCT 23 1987			
24. FUNERAL DIRECTOR NAME Connelly Funeral Home		ADDRESS 300 Mace Ave. 21221		25. DATE OF DEATH OCT 23 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The above remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

1963-10-10

1963-10-10



070762 NOV 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DAGMAR BOSWELL KERSHAW			2a. DATE OF DEATH MONTH DAY YEAR October 31, 1987		2b. HOUR M M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 24, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holly Hill Manor		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST John T. Boswell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Benson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213 34 3537		
17. INFORMANT Milton C. Feher,			ADDRESS Balto., MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arterio Sclerotic DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/25 , 19 87 , to 10/31 , 19 87 , that (I) (we) last saw the deceased alive on 10/31 , 19 87 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Hans Koetter			DEGREE MD		22c. DATE SIGNED 10/31/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Hans Koetter, MD			22e. ADDRESS 7600 Osler Drive, Towson, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/3/87	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. County, MD	
24. FUNERAL DIRECTOR NAME H.W. Jenkins & Sons Co.			25a. DATE REC'D. BY REGISTRAR NOV 3 1987		
			25b. REGISTRAR'S SIGNATURE H. W. Jenkins		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed after 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified.

069680 OCT 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Gustave F. Kiesling, Jr.			2a. DATE OF DEATH MONTH DAY YEAR Oct. 22, 1987		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 23, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Essex 21221	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1568 Galena Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Continental Can
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Gustav F. Kiesling			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Lovell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 218-22-4762		17. INFORMANT ADDRESS Gustav F. Kiesling III Same	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest or anaphylaxis DUE TO, OR AS A CONSEQUENCE OF (b) Cor pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: Hypertension					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Oct 29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Allen M Friedman MD		DEGREE MD		22c. DATE SIGNED 10/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen M Friedman		22e. ADDRESS 711 W 40 Street, #400 Balto 2121			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-26-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.					
24. FUNERAL DIRECTOR'S NAME Bruzdinski Funeral Home		25a. DATE REC'D. BY REGISTRAR OCT 23 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

060000 OCT 28 87

OCT 28, 1987

Alaska, U.S.

Grave

32

April 27, 1988

State

State

Bellevue County

x

SEA

Bellevue

Consolidated

Bellevue

1988 State Road

1988 State Road

1988 State Road 1988

x

Bellevue

Bellevue

State Road

State Road

State

State Road 1988

1988-88-88

State

State

Bellevue County, WA

10-25-87

State

OCT 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward W. Kinzel			2a. DATE OF DEATH MONTH DAY YEAR 10-5-87			2b. HOUR 7:58 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-19-1893		6. AGE (IN YEARS LAST BIRTHDAY) 94	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Rupton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber	
12b. KIND OF BUSINESS OR INDUSTRY Retired							
13a. STATE MD.		13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 2723 Waldor Drive 21234							
14. FATHER'S NAME FIRST MIDDLE LAST Christian Kinzel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Schmehl			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 046-01-0487		17. INFORMANT ADDRESS Betty Jane Brendel -2723 Waldor Dr. - 21234			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

STROKE.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-1-19-87, to 10-5-19-87, that (I) (we) last saw the deceased alive on 10-5-19-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A.H. Ghiladi				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-6-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.H. GHILADI, M.D.				22e. ADDRESS 7600 OSLER Dr. Towson MA 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-8-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD.	
24. FUNERAL DIRECTOR NAME John C. Miller, Inc.-6415 Belair Rd.-21206				25. DATE RECEIVED BY REGISTRAR OCT - 7 1987		26. REGISTRAR'S SIGNATURE Julia Benson-Randall	

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68613 OCT 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2815

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GREGORY		FIRST A		MIDDLE lan		LAST KLINK		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 10 9 1987		2b. HOUR 0214	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 14 1958 28 YRS.		6. AGE (IN YEARS) LAST BIRTHDAY 28 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD 10 9 1987		2d. HOUR 0300		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heavy Equip. Operator					
10. CITY OR TOWN OF DEATH Edgemere		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethlehem Blvd				12b. KIND OF BUSINESS OR INDUSTRY					
13a. RESIDENCE (IF IN HOUSE, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13. STATE PA		13b. COUNTY Fayette		13c. CITY OR TOWN Smithfield		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS RD 3 Box 245 B₁		13f. ZIP CODE 15478	
14. FATHER'S NAME FIRST MIDDLE LAST Joshua Klink				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Lowery				16. ADDRESS PA 15478			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 190-50-3378		17. INFORMANT Susan Klink ADDRESS RD3 Box 245 B₁ Smithfield							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 0214 P.M. 10 9 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger in auto accident	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION CITY OR TOWN COUNTY STATE Bethlehem Blvd. Balto. Md. 21219	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE J. C. Rossan O'Donovan		TIME (SPECIFY) Deputy		DATE SIGNED 10/9/87	
EXAMINER'S NAME (TYPE OR PRINT) J. C. ROSSAN O'DONOVAN		ADDRESS 2112 DUNDALK AVE, BALTO, MD 21221			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/12/87		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Point Marion Fayette PA	
24. FUNERAL DIRECTOR NAME 7922 Wise Ave. Dundalk, MD 21222 Duda-Ruck Funeral Home of Dundalk, Inc.				25a. DATE REC'D. BY REGISTRAR OCT 14 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS-501 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DMMH- 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Ethel Catherine Klunk					10 26 87					1130 AM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	White		3 18 1891		96 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania	Baltimore				Baltimore County MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Randallstown		B.C.G.H.				Store Owner and Homemaker				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland		Baltimore		Woodlawn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2221 Southland Road 21207		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
Joseph A. Althoff				Anna E. Crusti						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS				
No		216-32-5430		Mrs. Catherine A. Hynes		2221 Southland Road Baltimore, MD. 21207				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

Cardiopulmonary Failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Edmund P. Thomas				MD		10/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Edmund P. Thomas				Baltimore General Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10/29/87		Woodlawn Cemetery		Woodlawn Baltimore MD.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133				OCT 29 1987		Edmund P. Thomas	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

010800 1301

RECEIVED
10/10/64
10/10/64
10/10/64

070726 NOV-1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Margaret Catherine KNAUER			2a DATE OF DEATH MONTH DAY YEAR October 31, 1987		2b HOUR 8:39a _M										
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 IF UNDER 24 HRS HOURS MIN.					
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		9b CITIZEN OF WHAT COUNTRY? U.S.A.		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD									
10 CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife			12b KIND OF BUSINESS OR INDUSTRY Home keeping						
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland						13c COUNTY Baltimore		13d CITY OR TOWN Perry Hall		13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f STREET ADDRESS / ZIP CODE 4121 Perry View Rd. 21236			
14 FATHER'S NAME FIRST MIDDLE LAST Peter Winkler				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Winkler Reinfelds				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 219-20-6017		17 INFORMANT ADDRESS Mr. Richard J. Knauer, Balto.Md. 21236	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure and Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (d) _____ DUE TO, OR AS A CONSEQUENCE OF (e) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 31</u> , 19 <u>87</u> , to <u>October 31</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 31</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) view the body after death.															
22b SIGNATURE <i>David Zajano MD</i>				DEGREE				22c DATE SIGNED 10----31-87							
22d PHYSICIAN'S NAME (TYPE OR PRINT) David Zajano, M.D.				22e ADDRESS 9000 Franklin Square Dr. Balto., MD 21237											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 11-3-1987		23c NAME OF CEMETERY OR CREMATORY St. Joseph Church Cem.				23d LOCATION CITY OR TOWN COUNTY STATE Fullerton Balto. Md.					
24 FUNERAL DIRECTOR NAME E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087				25a DATE REC'D. BY REGISTRAR NOV 03 1987				25b REGISTRAR'S SIGNATURE <i>Julia Bender-Randall</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

070498 NOV-28

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER EDWARD KOCIENDA			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 28, 1987			2b. HOUR P.M. 6:58 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 9 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STOCK ROOM CLERK		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST STANLEY NMN KOCIENDA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALEXANDRA NMN MICKUCKA		13e. STREET ADDRESS 326 S. COLLINGTON AVENUE 21231			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WORLD WAR II 215 07 1742		17. INFORMANT ADDRESS CLINICAL RECORDS, VAMC, FORT HOWARD, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>AMYOTROPHIC LATERAL SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PARKINSON'S DISEASE</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JULY 2</u> , 19 <u>87</u> , to <u>OCTOBER 28</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>OCTOBER 28</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>Tang</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIN F. TANG, M.D.		22e. ADDRESS VA MEDICAL CENTER, FORT HOWARD, MD 21052					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/31/87		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME B. Dabrowski & Son 2818 E. Baltimore St.				25a. DATE REC'D. BY REGISTRAR OCT 30 1987			
				25b. REGISTRAR'S SIGNATURE <i>Julia S. ...</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
FEB 10 1960
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

070184 OCT 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alfred P. Kolinsky			2a. DATE OF DEATH MONTH DAY YEAR October 23, 1987			2b. HOUR 9:00 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 17, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Systems Engineer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Kolinsky		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Clearfield		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 180-16-2295		17. INFORMANT ADDRESS Mrs. Penelope C. Kolinsky Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jeffrey Palmer M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/24/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-24-87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR OCT 28 1987		25b. REGISTRAR'S SIGNATURE John B. ...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in the funeral director's office. Page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Page 4 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

068288 OCT 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

MARGARET K. Koller

2a. DATE OF DEATH

MONTH

DAY

YEAR

10 2 87

2b. HOUR

10³⁰ AM

3. SEX

FEMALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH

DAY

YEAR

10 05 02

6. AGE (IN YEARS, LAST BIRTHDAY)

84

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

BALTO. MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8.

MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CO.

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Medison Nursing Center

12a. USUAL OCCUPATION

HOUSE WIFE

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

MARYLAND

13a. STATE

13b. COUNTY

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

6710 QUEENSFERRY RD. 21239

14. FATHER'S NAME

HARRY

MIDDLE

BROWN

LAST

15. MOTHER'S MAIDEN NAME

MARGARET

MIDDLE

LEONHARDT

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN) NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES) 215-58-2341

17. INFORMANT

FAMILY RECORDS

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Thrombosis

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 6-5 19 86, to 10-2 19 87, that (I) (we) last saw the deceased alive on 9-8 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

(Signature)

DEGREE

MD

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

10-5-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

HAROLD B. BOB

22e. ADDRESS

7220 PARK HEIGHTS AVE

22f. CITY OR TOWN

21208

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

10-05-1987

23c. NAME OF CEMETERY OR CREMATORY

DULANEY VALLEY

23d. LOCATION

CITY OR TOWN

COCKEYSVILLE

COUNTY

BALTO. CO. MD.

24. FUNERAL DIRECTOR

EVANS CHAPEL OF MEMORIES

ADDRESS

25a. DATE RECD. BY REGISTRAR

OCT 09 1987

25b. REGISTRAR'S SIGNATURE

(Signature)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

88200 011301



069412 OCT 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HATTIE M. KRAMP			2a. DATE OF DEATH MONTH DAY YEAR 10 11 1987		2b. HOUR 5:30am	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-15-1900		6. AGE (IN YEARS (LAST BIRTHDAY)) 87
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 218-30-6699		17. INFORMANT ADDRESS Donald Kramp -11929 Fernshire Rd. 20878				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) END STAGE CHF DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 10/11/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Shirley Thompson		DEGREE		22c. DATE SIGNED 10/11/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Shirley Thompson, MD
22e. ADDRESS SAINT JOSEPH'S HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-21-87		23c. NAME OF CEMETERY OR CREMATORY Moreland		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md.
24. FUNERAL DIRECTOR Ruck Towson Funeral Home, Inc., Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR OCT 21 1987		25b. REGISTRAR'S SIGNATURE Julie Burden-Randall

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 8 1 4

FOR
STATE
REGISTRAR

REG. NO.

069899 OCT 27-87

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Louise C. KneB</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Oct. - 10-23-1987</i>		2b. HOUR <i>1:43A.M.</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9-15-1899</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>88</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>USA MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Balto. MD</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Joseph Hospital</i>		12a. USUAL OCCUPATION (IF WORKING LIFE) <i>Homemaker</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MARYLAND</i>			13b. CITY OR TOWN <i>BALTIMORE</i>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE <i>9628 Oak Summit Avenue 21234</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Henry F. Becker</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Augusta Wagner</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217260814</i>		17. INFORMANT ADDRESS <i>Shirley C. Chmielewski 9628 Oak Summit Avenue</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Acute myocardial infarction*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Arteriosclerotic Cardiovascular Disease*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Beatrice P. Dizon, M.D.</i>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>10/23/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BEATRIZ P. DIZON</i>		22e. ADDRESS <i>St. Joseph Hospital Venson, 21204</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>10-26-87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>
24. FUNERAL DIRECTOR NAME <i>Hyatt</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 26 1987</i>	
25b. REGISTRAR'S SIGNATURE <i>Julia Dizon-Rindone</i>		25c. REGISTRAR'S NAME <i>Julia Dizon-Rindone</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 28192			
1. DECEASED NAME (TYPE OR PRINT) GEORGE A KUES				2a. DATE OF DEATH MONTH DAY YEAR 10-16-87			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1-20-14		6. AGE (IN YEARS, LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec.-Treasurer		12b. KIND OF BUSINESS OR INDUSTRY Meat/Cut.117	
13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Balto.				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Henry Kues				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-10-3496		17. INFORMANT ADDRESS Debra Kirchner 9416 Perglen Rd.21236			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic brain tumor DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-16-87 , 19 87 , to 10-16 , 19 87 , that (I) have lost saw the deceased alive on 10-16 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) have (did) (did not) view the body after death.							
22b. SIGNATURE Beatrice P. Dizon M.D. DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/16/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEATRIZ P. DIZON				22e. ADDRESS St. Joseph Hospital, Towson, 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 19, 1987		23c. NAME OF CEMETERY OR CREMATORY Garden of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 21213				DATE REC'D. BY REGISTRAR OCT 20 1987		25. REGISTRAR'S SIGNATURE Julia Davidson-Rudace	

THIS IS TO BE DELETED

068611 OCT 15 87

FOR
STATE
REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- DECEASED NAME (TYPE OR PRINT)		FIRST DOUGLAS		MIDDLE SHAWN		LAST KYTE		2a. DATE KNOWN OF EST. DEATH MATED 10 10 19 87		2b. HOUR 11:30 M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-6-58		6. AGE (IN YEARS) LAST BIRTHDAY 29 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 10 10 19 87		7d. HOUR 11:30 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8029 Stratman Road						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Radiology- Johns Hopkins		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8029 Stratman Road 21222			
14. FATHER'S NAME FIRST MIDDLE LAST James L. Jones						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lois Campbell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-74-3580		17. INFORMANT ADDRESS James L. Jones 8029 Stratman Road 21222							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>HISTORY OF SEIZURE DISORDER HISTORY OF CLOSED HEAD INJURY > 10 yrs ago.</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Jm Nisoff</i>				TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER				DATE 10/10/87			
EXAMINER'S NAME (TYPE OR PRINT) J. M. NISOFF, MD				ADDRESS 9000 FRANKLIN SQUARE DR. BALTO, MD 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-13-87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge				23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR OCT 14 1987				25b. REGISTRAR'S SIGNATURE <i>John Duda-Ruck</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL INK IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM NO. 3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) THOMAS Charles KYLE					2a. DATE OF DEATH MONTH DAY YEAR 10-14-87			2b. HOUR 5:30A_M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 07 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer			12b. KIND OF BUSINESS OR INDUSTRY Self		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9407 Fullerdale Ave. 21234				
14. FATHER'S NAME FIRST MIDDLE LAST Charles Edward Kyle					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Elizabeth Pentz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Baltimore, Md. 21234 Margaret O. Kyle, 9407 Fullerdale Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a MULTIPLE CEREBROVASCULAR ACCIDENTS, -HYPERTENSION											
19a. DATE OF OPERATION 10-9-87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FOR ENDOSCOPIC GASTROSTOMY				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 10-7-87 19____, to 10-14-87 19____, that (we) last saw the deceased alive on 10-14-87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Francis T. Khoo					DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED 10-14-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS T- KHOO					22e. ADDRESS St. Joseph Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Oct. 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Green Mount			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, Md. 21214						25a. DATE REC'D. BY REGISTRAR OCT 15 1987 REGISTRAR'S SIGNATURE John Burton					

BP

OCT 19 1985

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Per Ph, Call fr. P.H., 11/6/87, / GB
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 7 2 8 1 1

REG. NO.

1. FOR STATE REGISTRAR Item 5, & 6,			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
DECLASED NAME (TYPE OR PRINT) David LaBoo			10/6/87			M		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 10 16	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.					
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (Home) 8626 Dovedale Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Randallstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8626 Dovedale Rd. 21133				
14. FATHER'S NAME FIRST MIDDLE LAST Frank LaBoo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zina McCoy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 248-26-4538		17. INFORMANT ADDRESS Louella LaBoo 8626 Dovedale Rd. 21133				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio Sclerotic Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Refected CVA; Blindness billes; COPD</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4-26-</u> 19 <u>79</u> to <u>8-4-</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8-4-</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>DSSALY</u>				DEGREE			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DARSHAN S. SALUJA				22e. ADDRESS 1600 MT Royal Ave, Balto 21217				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/12/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Md.		
24. FUNERAL DIRECTOR NAME Chas. A. Rice FHPA 1300 Eutaw Pl.				25a. DATE REC'D. BY REGISTRAR OCT 15 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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177 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTA M. LANCEA			2a. DATE OF DEATH MONTH DAY YEAR 10/20/87		2b. HOUR 7:44pm		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR AUG 00 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUMANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO COUNTY MD	
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN NURS. HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHNNY MDLDOVAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ILENA		16. SOCIAL SECURITY NO. 213-74-8508			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) —		17b. INFORMANT MARY VALENTINO		17c. ADDRESS 314 WHITFIELD RD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.H.F. - Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Myocardial Infarction (c) — DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/11/86 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 10/20/87			
22a. I certify that (I) (this hospital) attended the deceased from 10/20/87 to 10/20/87 that (I) (we) lost saw the deceased alive on 10/20/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not see the body after death.							
22b. SIGNATURE George D. Gooch		DEGREE —		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE D. GOOCH		22e. ADDRESS 3350 Wilman Dr. Balt MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/24/87		23c. NAME OF CEMETERY OR CREMATORY CRESTLAWN		23d. LOCATION CITY OR TOWN COUNTY STATE HOWARD MD.	
24. FUNERAL DIRECTOR NAME EDWARD J. WEBER & H.		ADDRESS 5311 EDMONDSON AVE		25a. DATE REC'D. BY REGISTRAR OCT 23 1987		25b. REGISTRAR'S SIGNATURE —	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Their place remains on the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 otherwise injury, or other traumatic event, the medical examiner must be notified of this.

200 40 500

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BENJAMIN LAPIDES			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 28, 1987			2b. HOUR 2 A. M.			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 21, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 SLADE AVE., APT. 806 (21208)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY BOTTLING CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST MAX LAPIDES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE SOBEL			16. STREET ADDRESS / ZIP CODE 11 SLADE AVE., APT. 806 (21208)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. JEANNE GOLPOB P.O. Box 334 RIDERWOOD, MD 21139				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNG WITH METASTASES 3 YRS DUE TO, OR AS A CONSEQUENCE OF (c) 3 YRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ATRIAL FIBRILLATION (chronic) POLYMYALGIA RHEUMATICA									
19a. DATE OF OPERATION 9/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF LUNG			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 68 , 19 68 , to 28 OCT , 19 87 , that (I) (we) lost saw the deceased alive on 22 OCT , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Abraham Genecin MD			DEGREE MD			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABRAHAM GENECIN MD			22e. ADDRESS 611 PARK AVE BALT, MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11/1/87		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTIMORE, MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.					25a. DATE REC'D. BY REGISTRY NOV 5 1987				
6010 REISTERSTOWN RD. BALTIMORE, MD 21215					25b. REGISTRAR'S SIGNATURE [Signature]				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
FEB 10 1964

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST LOUIS KENNETH LASSAHN			MONTH DAY YEAR 10-27-87			8:45 AM		
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
MALE	WHITE	MONTH DAY YEAR 10 01 1915		72 YRS		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	U.S.A.			BALTIMORE County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson	ST JOSEPH HOSPITAL			Teacher		Baltimore City		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland	Baltimore			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1832 E. Joppa Rd. 21234		
14. FATHER'S NAME FIRST MIDDLE LAST Louis C. Lassahn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian V. Kiaser					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes WW II			213-12-4440		Helen Lassahn 1832 E. Joppa Rd. 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF LUNG (SQUAMOUS CELL TYPE) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 10-19-87, 19____, to 10-27-87, 19____, that (we) last saw the deceased alive on 10-27-87, 19____, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Francis T. Khoo			DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10-27-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS T. KHOO			22e. ADDRESS St. Joseph Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-30-87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Lassahu Funeral Home			ADDRESS 7401 Belair Rd. BALTO. Md. 21236		25a. DATE REC'D. BY REGISTRAR OCT 29 1987		25b. REGISTRAR'S SIGNATURE John Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled into the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <i>Margaret Satta</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>10-16-87</i>			2b. HOUR <i>1825 PM</i>	
1a. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 22, 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore Co., MD.</i>			
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore Co. General Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self Emp.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. CITY OR TOWN <i>A. A. Co.</i> 13c. CITY OR TOWN <i>Glen Burnie</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6426 Colonial Knoll Rd. 21061</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Satterfield</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Virginia Masson</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217 05 5936</i>		17. INFORMANT ADDRESS <i>White Marsh, Md. Mrs. Viola Thomas 6018 Loreley Beach Rd.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Associated Pulmonary Edema</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Associated renal failure.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>10-11</i> , 19 <i>87</i> , to <i>10-16</i> , 19 <i>87</i> , that (1) we last saw the deceased alive on <i>10-16</i> , 19 <i>87</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (1) we did not view the body after death.									
22b. SIGNATURE <i>Edward Slev</i>				DEGREE				22c. DATE SIGNED <i>10-16-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward Sherman</i>				22e. ADDRESS <i>5620 Liberty PL 2nd floor Randallstown, Md 21133</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/20/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>MITCHELL-WIEDEFELD HOME, INC.</i> ADDRESS <i>6500 York Rd.</i>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Rudolph</i>					

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068576 OCT 14 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

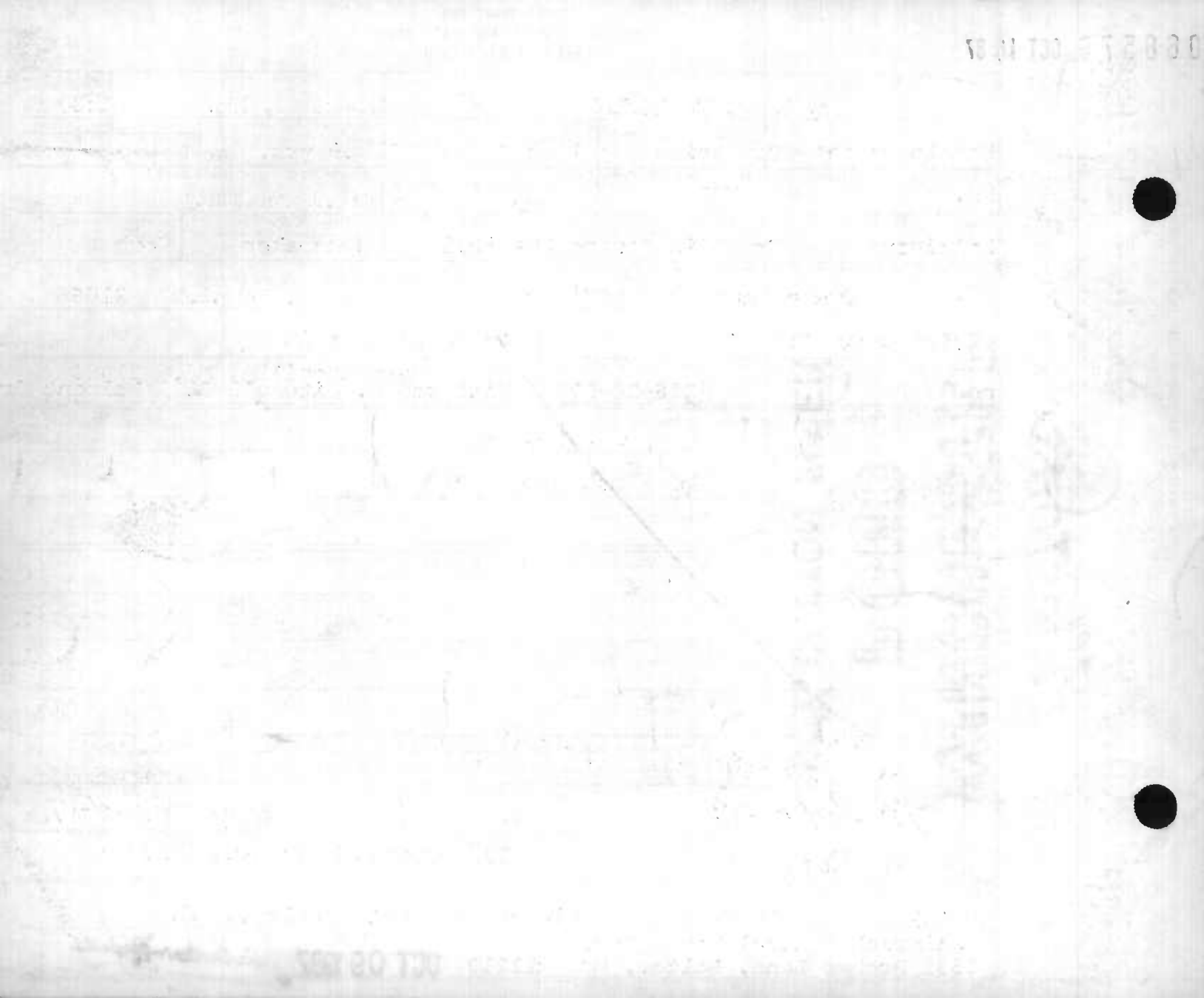
1. DECEASED NAME (TYPE OR PRINT) Mary Elizabeth LEBECK			2a. DATE OF DEATH MONTH DAY YEAR October 4, 1987			2b. HOUR 3:30 a.m.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10-8-97		6. AGE (IN YEARS LAST BIRTHDAY) 89 yrs.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Md.			13b. COUNTY Queen Anne		13c. CITY OR TOWN Stevensville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 146 S. Pennick 21666	
14. FATHER'S NAME FIRST MIDDLE LAST Christopher Lovell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Lowenstein							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-20-2764		17. INFORMANT ADDRESS Jarrettsville, Md. 21084 Winifred M. Mitchell 3831 Belmont Dr					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Upper Gastrointestinal Bleed</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>October 1</u> , 19 <u>87</u> , to <u>October 4</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>October 4</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>M. Roth MD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Roth, MD.			22e. ADDRESS 9000 Franklin Square Dr., 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-7-87		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR'S NAME Schumanek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213			25a. DATE REC'D. BY REGISTRAR OCT 09 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Darden</i>					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the detached pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



069989 OCT 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (PRINT)		FIRST MILDRED MIDDLE K. LAST LECKNER MILDRED KATHERINE LECKNER		2a. DATE OF DEATH MONTH DAY YEAR 10 15 87		2b. HOUR 10 15 PM	
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 9 5 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pickersgill - 615 Chestnut Ave. 21204		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto		13c. STREET ADDRESS / ZIP CODE 4318 Maple Hall Rd 21218			
14. FATHER'S NAME FIRST MIDDLE LAST Zachariah Gersuch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Henrietta Eagers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-0992		17. INFORMANT 615 Chestnut Ave., Towson, Md. 21204 Elizabeth Carroll 410 Pickersgill			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ STROKE Cerebral Arteriosclerosis 30 minute Year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from June 1987 to Oct 15 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE Keith Manley				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith Manley, M.D.				22e. ADDRESS Pot Springs Rd., Timonium, Md. 21093			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-19-87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc., Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR OCT 21 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Rader	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, all medical records should be retained for a minimum of 10 years.)

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FOR COTTON FIBRE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) Caroline Allison LEE					2a. DATE OF DEATH MONTH DAY YEAR October 13, 1987			2b. HOUR 10:00p M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 20, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Baltimore C		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ralph W. Lee					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Scott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 76 1867		17. INFORMANT ADDRESS Helen Webster 112 San Salvador St 33962 Naples, Florida						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Urosepsis. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Status post cerebrovascular accident, Seizure disorder.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from October 8, 1987 to October 13, 1987 , that (we) last saw the deceased alive on October 13, 1987 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-13-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robson A. Blanco, MD					22e. ADDRESS 9000 Franklin Square Drive, Balto., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 10/14/87		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Md.			
24. FUNERAL DIRECTOR NAME J. Willis Wells ADDRESS Chestertown, Md.					25a. DATE REC'D. BY REGISTRAR Oct 20 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

069923 OCT 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Myrtle I Lee			2a. DATE OF DEATH MONTH DAY YEAR 10/25/87		2b. HOUR 8:58 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05 05 06		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	8b. CITIZEN OF WHAT COUNTRY? U.S.	9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. Josephs Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Long Green	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4406 Long Green Rd. 21092	
14. FATHER'S NAME FIRST MIDDLE LAST James Wesley Isencock			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Francies		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-34-4000		17. INFORMANT ADDRESS Barbara F. Lee Long Green, MD 21092	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute Inferior Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs. 72 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/23 , 19 87 , to 10/25 , 19 87 , that (I) (we) last saw the deceased alive on 10/25 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert Frank Hamich		DEGREE MD		22c. DATE SIGNED 10/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Frank Hamich		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE OCT. 28, '87	23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CO. MD	
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON		ADDRESS 8521 LOCH RAVEN BLVD		25a. DATE REC'D. BY REGISTRAR OCT 26 1987	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate pages 1 and 2 and file with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

070475 NOV-2'87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine T. LEIBY			2a. DATE OF DEATH MONTH DAY YEAR October 29, 1987		2b. HOUR 1:35p _M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 2, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Penna.			13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 122 Main Street 17920
14. FATHER'S NAME FIRST MIDDLE LAST Robert Maurer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Shopinski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 198-28-2765		17. INFORMANT ADDRESS Joppatown, Md. Mrs. Marion T. Seybrecht 809 Fergusson Rd.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Renal Failure

DUE TO, OR AS A CONSEQUENCE OF
(b) Hemolytic - Uremic Syndrome

DUE TO, OR AS A CONSEQUENCE OF
(c) Metastatic Carcinoma

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10-28</u> , 19 <u>87</u> , to <u>10-29</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Anil Minocha</i>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-29-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anil Minocha, MD.			22e. ADDRESS 9000 Franklin Square Dr. Balto., MD 21237		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 2, 1987	23c. NAME OF CEMETERY OR CREMATORY Grace Reform	23d. LOCATION CITY OR TOWN COUNTY STATE Millgrove Columbia Penna.
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 30 1987	25b. REGISTRAR'S SIGNATURE <i>Julia D. ...</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

050453 MAY-58

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68871 OCT 16 1987

Item 18a, 20, 22a 10-30-87 G632

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28155
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARC DOUGLAS LESSANS			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10 10 19 87		2b. HOUR M 2:34 A.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 21, 1955	6. AGE (IN YEARS) LAST BIRTHDAY 32 YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 10 19 87	7d. HOUR M 2:34 A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH ROSEDALE ROSEVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp.		12b. KIND OF BUSINESS OR INDUSTRY C.P.A.	
13a. STATE MARYLAND			13b. CITY OR TOWN BALTIMORE	13c. STREET ADDRESS 4775 BYRON RD. 21208	
14. FATHER'S NAME FIRST MIDDLE LAST SEYMOUR LESSANS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MADELINE COOPER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-66-9638		17. INFORMANT ADDRESS MYRA LESSANS 4775 BYRON RD. 21208	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Floppy Mitral Valve DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-11-87					
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn St., Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/12/87	23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 100 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215			25a. DATE REC'D BY REGISTRAR OCT 15 1987 25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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069416 OCT 28 1987

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 8 1 5 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CARROLL R. LIGHTHISER			2a DATE OF DEATH MONTH DAY YEAR 10/18/87		2b HOUR 1422 PM
3 SEX Male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR 01/07/12	6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.		
10 CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSP.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Police Sgt.-Beth. Steel		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Baltimore		
13c CITY OR TOWN Cockeysville			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET ADDRESS / ZIP CODE 10315 J Malcolm Circle 21030					
14 FATHER'S NAME FIRST MIDDLE LAST Emil Lighthiser			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilamena Becker		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Doris V. Lighthiser - same as #13e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) Constrictive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) ACS CVD, severe APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/26 19 87		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/26 19 87 to 10/18 19 87 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 10/18 19 87 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.					
22b SIGNATURE Samuel C. H. Lee, M.D.		DEGREE M.D.		22c DATE SIGNED 10/19/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL C. H. LEE, M.D.		22e ADDRESS St. Joseph Hosp. Balto. MD 21204			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-21-87		23c NAME OF CEMETERY OR CREMATORY Moreland	
23d LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md.					
24 FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc., Towson, Md. 21204		1050 York Rd. ADDRESS		25a DATE REC'D. BY REGISTRAR OCT 21 1987	
		25b REGISTRAR'S SIGNATURE John Davidson			

MEMORANDUM

TO : DIRECTOR

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) August C. LIMMER			2a. DATE OF DEATH MONTH DAY YEAR October 5, 1987			2b. HOUR 12:53pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 3 13		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Silversmith	
12b. KIND OF BUSINESS OR INDUSTRY Samuel Kirk & Son							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. COUNTY Baltimore		13d. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Limmer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Barnacle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 220-07-2835		17. INFORMANT ADDRESS Mamie C. Limmer 8604 McDaniel Rd. 21237			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest secondary to congestive heart failure and ischemic cardiomyopathy DUE TO OR AS A CONSEQUENCE OF (b) Shock liver, renal failure, pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from October 2, 1987, to October 5, 1987, that (we) last saw the deceased alive on October 5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Maged Boles				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maged Boles, M.D.				22e. ADDRESS 9000 Franklin Square Dr., Balto. 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-7-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Lassahu Funeral Home				25a. DATE REC'D. BY REGISTRAR OCT 07 1987		25b. REGISTRAR'S SIGNATURE Julia L. [Signature]	

081300 OCT-88

OCT 07 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		DAY YEAR	
BERDIE VIOLA LOCKARD		October 14, 1987		1:15 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	September 13, 1894	93	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Towson	Meridian Nursing Center-Multi Med		Practical Nurse		Medical
13a. STATE		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE	
Maryland	Baltimore	Timonium	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	227 Deep Dale Dr. 21093	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Franklin Summers		Lottie Keller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-34-3835		Doris C. Miller Same	
18. CAUSE OF DEATH (Enter only one cause per line, but list all, and specify PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Recent CVA					25 Yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Recent CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10 October 1987, to 14 October 1987, that (I) (we) last saw the deceased alive on 12 October 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Charles F. O'Donnell, M.D.		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		10/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Charles F. O'Donnell, M.D.		7501 York Rd. Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Oct. 17, 1987		Parkwood	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR SIGNATURE	
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212		OCT 20 1987		Julia Baker-Richter	

BP

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070446 NOV-28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 8 1 5 9

1. DECEASED NAME (TYPE OR PRINT) Samuel		FIRST Samuel MIDDLE A. LAST Loeb		2a. DATE OF DEATH MONTH DAY YEAR 10-27-87		2b. HOUR 2:15 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 18, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 2300 Dulaney Valley Rd., 21204		14. FATHER'S NAME FIRST MIDDLE LAST Adam Franklin Loeb		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kanta			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 203-07-5989		17. INFORMANT Henry S. Gurski		ADDRESS -5615 Kenwood Ave., 21206	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0			
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/1 , 19 86 , to 10/27 , 19 87 , that (I) (we) lost saw the deceased alive on 10/26 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Carla S. Alexander		22c. DATE SIGNED 10/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carla S Alexander		22e. ADDRESS Dulaney Valley Rd. Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-30-87	
23c. NAME OF CEMETERY OR CREMATORY St. John's Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Host Penna.	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc., Towson, Md. 21204		25a. DECEASED BY REGISTRAR Oct 30 1987	
		25b. REGISTRAR'S SIGNATURE Julia Gordon-Rudner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

70472 NOV-20

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 8 1 6 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ASSUNTA		FIRST LOLLI		LAST		2a. DATE OF DEATH MONTH DAY YEAR October 27, 1987		2b. HOUR 6:15A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Italy		7b. CITIZEN OF WHAT COUNTRY? Italy		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Multi-Medical Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Baltimore,		13c. CITY OR TOWN Kingsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2501 Whitt Rd. 21087	
14. FATHER'S NAME FIRST MIDDLE LAST Demtrios Mori			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luigina Botini							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-1026		17. INFORMANT ADDRESS Mr. Dominic Lolli Same as #13e					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF: (b) GANGRENE LEFT LOWER EXTREMITY (c) ADVANCED ALZHEIMER'S DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 10/26 19 87 to 10/27 19 87 , that (I) (we) last saw the deceased alive on 10/26 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Ceballos, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/30/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lilia Ceballos, M.D.			22e. ADDRESS 120 Sr. Pierre Dr. - Suite 504 - Baltimore, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment			23b. DATE 10-30-87		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.					ADDRESS Baltimore, Md.		25a. DATE RECEIVED BY REGISTRAR OCT 30 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100-101-57405

090647 NOV 13 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
FOR STATE REGISTRAR						REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <i>William V. Lombard</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>10/29/87</i>			2b. HOUR <i>1843</i>			
3. SEX <i>Male</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 25 15</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MINS	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WEST VIRGINIA</i>		9b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE COUNTY, MD</i>						
12. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ST. JOSEPH HOSPITAL E.R.</i>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>ENGINEER</i>			15. KIND OF BUSINESS OR INDUSTRY <i>ELECTRICAL</i>			
16. USUAL RESIDENCE (IF NEARBY HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
17a. STATE <i>MARYLAND</i>		17b. COUNTY <i>BALTIMORE</i>		17c. CITY OR TOWN <i>21204</i>		18. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. STREET ADDRESS / ZIP CODE <i>20 TREEWAY CT. APT 4C 21204</i>				
20. FATHER'S NAME (FIRST LAST) <i>ROY Z. LOMBARD</i>						21. MOTHER'S MAIDEN NAME (FIRST LAST) <i>ROSE KULCHER</i>						
22a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				22b. SOCIAL SECURITY NO. <i>234-16-1418</i>		23. INFORMANT ADDRESS <i>RINA D. LOMBARD 20 TREEWAY CT. APT 4C</i>						
24. CAUSE OF DEATH (Enter only one cause per line and do not include any condition which is a consequence of the terminal disease or condition given in Part 1.)												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ruptured abdominal aortic aneurysm</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>due to or as a consequence of</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)												
25a. DATE OF OPERATION				25b. CONDITION FOR WHICH OPERATION WAS PERFORMED				26a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10/29 87</i>				27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
28a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				28b. PLACE OF INJURY (GIVE HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>18. St. Joseph Hosp. Balt. MD</i>				28c. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i>				
29. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>10/29/87</i> to <i>10/29/87</i> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>10/29/87</i> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.												
30a. SIGNATURE <i>Samuel Ch. Johnson</i>						30b. DEGREE <i>MD</i>			30c. DATE SIGNED <i>10/30/87</i>			
31a. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SAMUEL CH. JOHNSON</i>						31b. ADDRESS <i>18. St. Joseph Hosp. Balt. MD 21204</i>						
32a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>				32b. DATE <i>OCT. 31, 1987</i>		32c. NAME OF CEMETERY OR CREMATORY <i>GREEN MOUNT CREMATORY</i>		32d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i>				
33. FUNERAL DIRECTOR NAME <i>WILLIAM E. JOHNSON</i>						33b. ADDRESS <i>8521 LOCH RAVEN BLVD.</i>		34a. DATE REC'D. BY REGISTRAR <i>NOV 02 1987</i>		34b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

BP

100-101154-090



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH F. LONGLEY			2a. DATE OF DEATH MONTH DAY YEAR 10/10/87		2b. HOUR 6:15 A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 24 90		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Forest Haven Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Collar Setter		12b. KIND OF BUSINESS OR INDUSTRY Shirt Factory
13a. STATE Maryland	13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2735 Wilkens Avenue, 21223	
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas S. Fink		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Broecker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-07-6797		17. INFORMANT ADDRESS Genevieve Longley, 1527 Park Grove Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia					
DUE TO, OR AS A CONSEQUENCE OF (c) Osteomyelitis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Osteomyelitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-23 , 19 86 , to 10-10 , 19 86 , that (I) (we) last saw the deceased alive on 10-8 , 19 86 , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harold B. Bob M.D.				22c. DATE SIGNED 10-10-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold B. Bob M.D.				22e. ADDRESS 7220 Park Heights 21208	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/13/87		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR OCT 13 1987	
25b. REGISTRAR'S SIGNATURE Julia Anderson-Pond				25c. REGISTRAR'S NAME Julia Anderson-Pond	

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 28163

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Allan LUTZ			2a. DATE OF DEATH MONTH DAY YEAR 10 9 87		2b. HOUR 0445AM						
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 10, 07		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		7. IF UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman-National		12b. KIND OF BUSINESS OR INDUSTRY Butter Co.			
13a. STATE Maryland						13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Lutz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				16. STREET ADDRESS / ZIP CODE 8809 Liberty Road 21133					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT Sharon Lutz		ADDRESS 60090		17. ADDRESS 1060 Driftwood Court Wheeling, Illinois			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Hypotension**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Dehydration**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Renal failure, D.M. hyperkalemia

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hafeez A. Syed m.d.				DEGREE		22c. DATE SIGNED 10/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFAEEZ A SYED M.D.				22e. ADDRESS BALTIMORE COUNTY GEN HOSP			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/14/87		23c. NAME OF CEMETERY OR CREMATORY Wards Chapel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown, Balto. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133				25a. DATE REC'D BY REGISTRAR OCT 13 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

069836 OCT 27 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 28104

1- FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)		LAWRENCE		MAHINSKE		REG. NO.	
2a DATE OF DEATH MONTH DAY YEAR		OCT. 24, 1987		2b HOUR		7 15 AM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		JULY 14, 1896		91 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
PENNSYLVANIA		U.S.A.				BALTIMORE COUNTY MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
CATONSVILLE		MERIDIAN NURSING HOME		CIVIL ENGINEER		STATE HIGHWAY	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
NORTH CAROLINA		WAKE		RALEIGH		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e STREET ADDRESS / ZIP CODE			
VINCENT MAHINSKE		KATHERINE STYCRICKLE		3017 ROTHGEB DRIVE 27609			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (YES, GIVE YEAR OR DATES)		17 INFORMANT ADDRESS		21228	
YES		UNKNOWN		CLAIRE KREBS 7314 Johnnycake Rd. Balto. Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) ASCVD WITH CHF							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SICK SINUS SYNDROME							
DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE BP 4 E U.T.I.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22a I certify that (I) (this hospital) attended the deceased from 9/4, 19 87, to 10/24, 19 87, that (I) (we) last saw the deceased alive on OCT 23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
DR. JOHN H. SHAW						10/24/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	
		5800 EDMONDSON AVE BALTO MD		Burial		10/29/87	
				23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
		Restlawn Memorial Pk.		Raleigh		North Carolina	
24 FUNERAL DIRECTOR		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Leroy & Russell Witzke Funeral Home Catonsville		OCT 26 1987		Julia Gordon-Randall			
1630 Edmondson Avenue Baltimore Maryland 21228							

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00283 121510

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

37 28105

1- FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) ANNA O. MALLON			2a. DATE OF DEATH MONTH DAY YEAR October 11, 1987		2b. HOUR 7:45 A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 17, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK, MOST OR WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY State of Md.

13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1506 Edmondson Ave., 21228
14. FATHER'S NAME FIRST MIDDLE LAST John Misikofsky			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Bunk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 01 2924		17. INFORMANT ADDRESS M's Cornelia Rheb 1506 Edmondson Ave. 21228		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Cerebrovascular accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 8, 1987 to Oct. 10, 1987 , that (I) (we) last saw the deceased alive on Oct. 10, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Shassem Bourmotabed, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10-11-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHASSEM BOURMOTABED		22e. ADDRESS Balto. County Gen. Hospital	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct 14, 1987	23c. NAME OF CEMETERY OR CREMATORY ST Johns Lutheran	23d. LOCATION CITY OR TOWN COUNTY STATE Howard Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke Funeral Home Inc, 4112 Old Columbia Pike Ellicott city Md.		25a. DATE REC'D. BY REGISTRAR OCT 15 1987	25b. REGISTRAR'S SIGNATURE W. A. Anderson-Pandee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove all other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

70 61 100 1 233-80

069040 OCT 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Benjamin S. MARKLEY			2a. DATE OF DEATH MONTH DAY YEAR October 17, 1987			2b. HOUR a 12:04 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 25, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Lewistown, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County			MD.	
10. CITY OR TOWN OF DEATH Rossville 21237		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN BALTIMORE CITY, GIVE STREET NUMBER) Franklin Sq. Hospital				12a. MARITAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		12b. KIND OF BUSINESS OR INDUSTRY Boating		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Markley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Sciebley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 20 7861		17. INFORMANT ADDRESS 233 Nanticoke Rd. Benjamin Markley Jr. Balto., Md. 21221						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - Hypoxic Encephalopathy									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 20, 1987 to October 17, 1987 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on October 17, 1987 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.										
22b. SIGNATURE Kenneth Lum			DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/17/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Lum, M.D.			22e. ADDRESS 9000 Franklin Square Dr. 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/20/87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.		
24. FUNERAL DIRECTOR Wojcinski Funeral Home PA 1407 Old Eastern Ave. 21221					25a. DATE REC'D. BY REGISTRAR OCT 19 1987			25b. REGISTRAR'S SIGNATURE Julia Denison-Randall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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068182 OCT 9 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 28107

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE G. MARSLETT			2a. DATE OF DEATH MONTH DAY YEAR 10 06 87		2b. HOUR 10:40 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 1, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 49	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Co. MD.	
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N. CHARLES STREET G.B.M.C.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Md.			13b. CITY OR TOWN Balto.	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 31 Brookbury Dr. 21136
14. FATHER'S NAME FIRST MIDDLE LAST Robert C. Marslett Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie G. Crouse		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-34-5738		17. INFORMANT ADDRESS Miss. Vanessa M. Wischhusen Reisterstown, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CA. OF THYROID DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 DAYS
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a		
19a. DATE OF OPERATION 09-22-87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RESPIRATORY DIFFICULTY - (Tracheotomy)	20a. AUTOPSY? NO <input type="checkbox"/> YES <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 09/22, 19 87 to 10/06, 19 87 , that (I) (we) last saw the deceased alive on 10/06 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE DR. ALAIN SHIKHANI DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/6/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ALAIN SHIKHANI		22e. ADDRESS G.B.M.C., 6701 N. CHARLES STREET, 21204

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 10/8/87	23c. NAME OF CEMETERY OR CREMATORY Garden of Faith Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.
24. FUNERAL DIRECTOR Eline Funeral Home Reisterstown, Md. 21136		25a. DATE REC'D. BY REGISTRAR OCT 8 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Swisher-Randall</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Would be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		REG. NO.		2b. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		October 23, 1987		11:20pm			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		February 25, 1987		90		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		USA				Baltimore County						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Rossville		Franklin Square Hospital		Housewife		Own Home							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Baltimore		Edgemere		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2422 Wythe Ave.		21219			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
John		Cecilia		Whitlock		Branscomb							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		212-74-3962		Vincent Martin		2422 Wythe Ave.		21219					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coma, Multiple Cerebrovascular Accidents, and DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 22, 1987, to October 23, 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 23, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
Keith Parker, M.D.				10/23/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Keith Parker, M.D.		9000 Franklin Square Drive,		21237									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		10-27-87		Sacred Heart of Jesus		Baltimore Maryland							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222		OCT 28 1987		Julia Davidson-Parker									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068125 OCT-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARENCE E. MARTIN			2a. DATE OF DEATH MONTH DAY YEAR 10 / 5 / 87		2b. HOUR 930 PM
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 15 06	6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD		
10 CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Gen'l		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Carroll		
13c. CITY OR TOWN Eldersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5718 Strawbridge Terr. 21784		
14. FATHER'S NAME FIRST MIDDLE LAST Luther E. Martin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah A. Baublitz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 705-14-0016		17. INFORMANT ADDRESS Mrs. Virginia J. Weber, Hanover, Pa.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Edmund P. Tkaczuk	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/5/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDMUND P. TKACZUK	22e. ADDRESS Balt Gt. General Hosp	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-8-87	23c. NAME OF CEMETERY OR CREMATORY Grace Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Upperco Balto Md.
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home, Hampstead, Md.		25a. DATE REC'D. BY REGISTRAR OCT 8 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

THE
FEDERAL
BUREAU OF
INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

068287 OCT 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>William L. Martin</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>OCTOBER 5, 1987</u>			2b. HOUR <u>11:40</u> A.M.				
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>JAN. 31, 1920</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE COUNTY</u> MD.				
10. CITY OR TOWN OF DEATH <u>PARKVILLE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>MERIDIAN NURSING CENTER</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>CAF. WORKER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. CO.</u>		
13a. STATE <u>MARYLAND</u>			13b. COUNTY <u>BALTIMORE</u>		13c. CITY OR TOWN <u>PARKVILLE</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>2712 MAPLE AVE.</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>William H. HOGAN</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MARIE BOHANO</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>215 14 7848A</u>		17. INFORMANT <u>FAMILY RECORDS</u>				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE M.I. INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Edmar E. Parra M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>OCT. 6, 1987</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. EDMAR E. PARRA</u>					22e. ADDRESS <u>7122 HARFORD ROAD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>10-8-1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GARRISON FOREST</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>GARRISON BALTO. MD.</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>EVANS CHAPEL OF MEMORIES ROAD</u>					25a. DATE REC'D. BY REGISTRAR <u>OCT 09 1987</u>					
					25b. REGISTRAR'S SIGNATURE <u>Julia Pearson-Baker</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

009565 011301

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 01-13-01 BY 60322 UCBAW

069721 OCT 26 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28171

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Hollis Durcan Mason			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 18 19 87			2b HOUR M 4:30P M																																																		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1957		6 AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 29 YRS.		7c DATE PRONOUNCED DEAD MONTH DAY YEAR 10 18 19 87		7d HOUR M																																																	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD																																																		
10 CITY OR TOWN OF DEATH Baltimore			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 509 Regester Avenue						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b KIND OF BUSINESS OR INDUSTRY Law																																																
13a STATE Maryland												13b CITY OR TOWN Baltimore												13c CITY OR TOWN Baltimore												13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												13e STREET ADDRESS 509 Regester Ave. 21212											
14 FATHER'S NAME FIRST MIDDLE LAST Everett Paul Mason												15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miriam V. M. Mann																																															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No												16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-70-9669												17 INFORMANT ADDRESS Miriam V.M. Mason 111 Cross Keys Rd. Baltimore, Md. 21210																																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to chest</u> (Handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)																																																											
19a DATE OF OPERATION												19b CONDITION FOR WHICH OPERATION WAS PERFORMED?												20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																			
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b TIME OF INJURY HOURS MONTH DAY YEAR P.M. 10 18 19 87												21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted																																			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>												21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home												21f LOCATION STREET CITY OR TOWN COUNTY STATE 509 Regester Ave Baltimore, MD.																																			
22a I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																																											
ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i>												TITLE (SPECIFY) Assistant MEDICAL EXAMINER												DATE SIGNED 10/19/87																																			
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.												ADDRESS 111 Penn St. Balto.MD.																																															
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation												23b DATE Oct. 20, 1987												23c NAME OF CEMETERY OR CREMATORY Greenmount												23d LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland																							
24 FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.												ADDRESS 6500 York Rd. Balto., Md. 21212												25a DATE REC'D. BY REGISTRAR OCT 23 1987										25b REGISTRAR'S SIGNATURE <i>J. J. [Signature]</i>																									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN NEW 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

0 6 8 5 1 0 2 2 0 7

068878 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and accurately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MILTON P. MASON			2a. DATE OF DEATH MONTH DAY YEAR 10-13-87			2b. HOUR 1545H				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6 1901		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Domino Sugar		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 815 Winters Lane Apt. 205 21228	
14. FATHER'S NAME FIRST MIDDLE LAST Duloney W. Mason			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dollie Pilchard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-09-6549		17. INFORMANT ADDRESS Milton P. Mason Jr. 2114 Forest Ridge Rd. 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia's DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dehydration									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10-13-87 to 10-13-87 , that (I) (we) last saw the deceased alive on 10-13-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.										
22b. SIGNATURE R. Siry			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-13-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAEAT Y. GIRGIS			22e. ADDRESS Baltimore County HOSP.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-16-87		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md.					25a. DATE REC'D. BY REGISTRAR OCT 16 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			

BP

067697 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MELVIN J. MASTROCOLA				2a. DATE OF DEATH MONTH DAY YEAR 10-2-87			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10-8-1918		6. AGE (IN YEARS (LAST BIRTHDAY)) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY - MD	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12 PARHAM CIRCLE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TIMEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY CITY	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH A. MASTROCOLA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE G. ROBERTS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) W.W. II		16b. SOCIAL SECURITY NO. W.W. II		17. INFORMANT ADDRESS 21237 Mrs. Dolores T. Mastrocola - 12 Parham Circle			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: H/O MYO CARDIAL INFARCTION, COPD.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE STUART		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GODFREDO		22e. ADDRESS STUART M.D. 406 EASTERN BLVD 21221					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-5-87		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.	
24. FUNERAL DIRECTOR NAME Paul Miller - 7527 Hanford Rd				25a. DATE REC'D. BY REGISTRAR OCT 5 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

007003 OCT-80

10-5-87

MELVIN J. WILSON

88

10-8-1918

W

M

X

W.S.A.

MARYLAND

1-10-1940

X

1-10-1940

M

MARIE A. ROBERTS

MARIE A. ROBERTS

WILLIAM T. ROBERTS - 10-10-1918

WILLIAM T. ROBERTS



10-10-1918

10-10-1918



10-10-1918

10-10-1918

068183 OCT-1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
DOLORES		F.		MATHEWS		10		05	87	10:30 P M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White		April 28, 1924		63 YRS		MONTHS		DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
Minnesota		USA				BALTIMORE COUNTY MD.						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY						
TOWSON		6701 N. CHARLES STREET G.B.M.C.		Homemaker		Own Home						
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE		21204		
MD		Balto.		Ruxton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2 Ruxton Ridge Garth				
14 FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST		
William		J.		Frank		Bertha		Schaumann				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS						
No		472 22 9980		Henry Burke Mathews,		Same						
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive M.I. and Cardiac Arrest</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from <u>6/4</u> 19 <u>87</u> to <u>6/4</u> 19 <u>87</u> , that (I) (we) lost sight of the deceased on <u>6/4</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED						
<i>Robert J. Mahon</i>						10/6/87						
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS										
Robert J. Mahon, M.D.		7620 York Rd Towson, Md 21204										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE						
Cremation		10/7/87		Green Mount		Balto., MD						
24 FUNERAL DIRECTOR NAME		H.W. Jenkins & Sons Co.		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
				OCT 8 1987		<i>Julia Gordon-Ruders</i>						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

067782 OCT-1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Andrew MAYR, Jr. <i>GEORGE A. MAYR Jr.</i>		2a. DATE OF DEATH MONTH DAY YEAR 10 2 87		2b. HOUR 3:55 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 22, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	7. IF UNDER 1 YEAR MONTHS DAYS 3 55 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saint Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Food Stores
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Linover	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 118 Sipple Avenue 21236	
14. FATHER'S NAME FIRST MIDDLE LAST George Andrew Mayr, SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna M. Muller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2 212-12-9359		17. INFORMANT ADDRESS: Baltimore, Maryland Anna M. Mayr 118 Sipple Avenue 21236	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Oat Cell Carcinoma of the Lung with liver metastasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Beatriz P. Dizon, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEATRIZ P. DIZON		22e. ADDRESS St. Joseph Hospital, Towson, 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 6, 1987		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD.		23e. FUNERAL DIRECTOR NAME ADDRESS Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, MD 21206			
24. FUNERAL DIRECTOR NAME ADDRESS Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, MD 21206		25a. DATE RECEIVED BY REGISTRAR OCT 06 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with me 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

070461 NOV

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 28176	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
HELEN			MAYTIN			OCTOBER 27, 1987			6:30P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		CAUCASIAN		JAN. 26, 1907		80		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE COUNTY			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
RANDALLSTOWN		MERIDIAN NURSING HOME				DENTAL ASSISTANT		DENTAL OFFICE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS / ZIP CODE (21209)					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6318 GREENSPRING AVE., APT. T103			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
UNKNOWN				GINSBERG				UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		215-38-0165		RONALD MAYTIN		3916 AVONHURST CIRCLE 21208					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>										<u>acute</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration</u>										<u>acute</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia + sepsis</u>										<u>24 hrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Severe senile dementia (Alzheimer's)</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN COUNTY STATE					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET							
22a. I certify that (I, this hospital) attended the deceased from <u>2/7</u> 19 <u>86</u> to <u>10-27</u> 19 <u>87</u> , that (I) (we) lost saw the deceased <u>above</u> <u>10-29-87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>H. Gerald Oster</u>				<u>MD</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
<u>H. Gerald Oster</u>				<u>3635 Old Court Rd.</u>							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
BURIAL		10/29/87		BETH JACOB CEMETERY		FINKSBURG, CARROLL, MD					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME SOL LEVINSON & BROS., INC.						OCT 30 1987		<u>[Signature]</u>			
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28111
2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR 10 21 1987 7:52 PM
2b. HOUR

FOR
1- STATE
REGISTRAR
DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

1. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR

2d. HOUR

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

2e. HOUR

11. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)
M.D. Deputy

MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S NAME (TYPE OR PRINT)

ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

OCT 26 1987

Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCILING ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

184710 810000

184710 810000

068204 OCT 19 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles P. McComas			2a. DATE OF DEATH MONTH 10 DAY 7 YEAR 87			2b. HOUR 9:52 AM				
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH 07 DAY 04 YEAR 06		6. AGE (IN YEARS LAST BIRTHDAY) 81 YES MONTHS DAYS HOURS MIN.		7. IF UNDER 1 YEAR IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD				
10. CITY OR TOWN OF DEATH Towson MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wholesale & Retail Meat		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3900 N. Charles St. 21218		
14. FATHER'S NAME FIRST M. MIDDLE Lee LAST McComas			15. MOTHER'S MAIDEN NAME FIRST Francis MIDDLE P. LAST Polton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-20-8459		17. INFORMANT Mrs. Dorothea W. McComas				ADDRESS Same as #13e	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO, OR AS A CONSEQUENCE OF Contributing causes: (b) Sepsis & Sepsis Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Natividad D. de Leon, M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 10/7/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATIVIDAD D. DE LEON					22e. ADDRESS C/O ST. JOSEPH HOSPITAL TOWSON, MD, 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-9-87		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Maryland										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OCT 08 1987

W. B. - 11 - 30

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved.

2. The second part of the report is a description of the methods used in the study. It includes a list of the equipment and materials used and a description of the procedures followed.

3. The third part of the report is a description of the results of the study. It includes a list of the data obtained and a description of the analysis of the data.

4. The fourth part of the report is a discussion of the results of the study. It includes a comparison of the results with those of other studies and a discussion of the implications of the results.

5. The fifth part of the report is a conclusion. It includes a summary of the findings of the study and a statement of the conclusions drawn from the study.

6. The sixth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study.

7. The seventh part of the report is a list of appendices. It includes a list of the tables, figures, and other material included in the report.

8. The eighth part of the report is a list of acknowledgments. It includes a list of the people and organizations that have helped in the study.

9. The ninth part of the report is a list of distribution. It includes a list of the people and organizations to whom the report is being distributed.

10. The tenth part of the report is a list of other references. It includes a list of the books, articles, and other sources used in the study.

11. The eleventh part of the report is a list of other appendices. It includes a list of the tables, figures, and other material included in the report.

12. The twelfth part of the report is a list of other acknowledgments. It includes a list of the people and organizations that have helped in the study.

13. The thirteenth part of the report is a list of other distribution. It includes a list of the people and organizations to whom the report is being distributed.

14. The fourteenth part of the report is a list of other references. It includes a list of the books, articles, and other sources used in the study.

15. The fifteenth part of the report is a list of other appendices. It includes a list of the tables, figures, and other material included in the report.

16. The sixteenth part of the report is a list of other acknowledgments. It includes a list of the people and organizations that have helped in the study.

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008304 11-30

069931 OCT 27 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GERTRUDE N. MCGEEHAN			2a. DATE OF DEATH MONTH DAY YEAR OCT. 14, 1987			2b. HOUR 2:40 A			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 1, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 2:40 A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown		12b. KIND OF BUSINESS OR INDUSTRY --	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9 Timber Grove Rd. 21133	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT 606 Balto. Ave Towson, MD 21204 Alan McGeehan C/O Clifford Robinson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) Probably pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Probably pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 13, 1987 , to Oct. 14, 1987 , that (I) (we) last saw the deceased alive on Oct. 14, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Shamoun Pourmottabed, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10-14-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHASSEM POURMOTTABED				22e. ADDRESS Balto. County Gen. Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-22-87		23c. NAME OF CEMETERY OR CREMATORY Wards Chapel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore MD			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.				25a. DATE REC'D. BY REGISTRAR OCT 26 1987		25b. REGISTRAR'S SIGNATURE James Anderson-Randall			
8728 Liberty Rd. Randallstown, MD 21133									

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

069993 OCT 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME FIRST MIDDLE LAST Bertha McLean		MONTH DAY YEAR 10 15 87		5:50 P M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 12 1895		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Timonium	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5 Streamrun Court 21093		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland	13b. COUNTY Balto.	13c. CITY OR TOWN Timonium	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Hecht		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Zehnder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 072-14-6792		17. INFORMANT ADDRESS Mr. W. Douglas McLean Same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma Invasive Ductal Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma Unknown Source</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u> <u>when</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/13/87</u> , 19 <u>87</u> , to <u>Oct 19 87</u> , that (I) (we) last saw the deceased alive on <u>10/13/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James Quinlan M.D.</u> DEGREE				22c. DATE SIGNED <u>10/16/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Quinlan M.D.				22e. ADDRESS 7801 York Rd. 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/16/87		23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md.		23e. DATE REC'D. BY REGISTRAR OCT 21 1987		23f. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Rd.					

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BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 2818					
1. DECEASED NAME (TYPE OR PRINT) MARGARET E. MECASLIN				2a. DATE OF DEATH MONTH DAY YEAR October 20, 1987				2b. HOUR 10:05 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 13, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Monkton				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 17323 Westley Chapel Rd. 21111			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Mathias				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Snow					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-74-2706		17. INFORMANT ADDRESS Harry B. Mecaslin, III - same as #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Constrictive Neck Saddle DUE TO, OR AS A CONSEQUENCE OF (b) C.V.A DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct 24th 1987 to Oct 20th 1987 , that (I) (we) lost saw the deceased alive on Oct 20th 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. Kevin Quinn				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Kevin Quinn, M.D.				22e. ADDRESS 1205 York Rd. Timonium, Md. 21093					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-24-87		23c. NAME OF CEMETERY OR CREMATORY Jessop Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE OCT 28 1987		25b. REGISTRAR'S SIGNATURE Janis Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.							
1. FOR STATE REGISTRAR DECLARED NAME (TYPE OR PRINT) Edna Lillian Meister			2a. DATE OF DEATH MONTH DAY YEAR Oct. 16 1987			2b. HOUR M											
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 17, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.											
10. CITY OR TOWN OF DEATH Timonium		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9 Bailiffs Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker									
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9 Bailiffs Court 21093								
14. FATHER'S NAME FIRST MIDDLE LAST William Harrison Robertson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Schiffner												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-40-1462			17. INFORMANT ADDRESS Mrs. Louise Johnson same as 13e											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Old age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hypertension										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from Since 1977 19____ to 10-14-87 19____, that (I) (we) lost saw the deceased alive on 10-14-87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE [Signature]		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-21-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Allan Perez					22e. ADDRESS 1009 Frederick Road Balto. 21228												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 19, 1987		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland										
24. FUNERAL DIRECTOR Bryan W. Clary					25a. DATE REC'D. BY REGISTRAR OCT 26 1987		25b. REGISTRAR'S SIGNATURE [Signature]										
25c. ADDRESS 10 W. Padonia Road																	

BP _____

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MYRTLE ANN MEISTER			2a. DATE OF DEATH MONTH DAY YEAR October 19, 1987			2b. HOUR 2:00 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 - 17 - 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. UNDER 1 YEAR MONTHS DAYS 81		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney Towson Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Packer		12b. KIND OF BUSINESS OR INDUSTRY Candy Co.		
13a. STATE Maryland			13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 3025 Glenmore Ave. 21214			
14. FATHER'S NAME FIRST MIDDLE LAST Wildy Jackson Cook			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Emma Hubbard			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-12-9488A	
17. INFORMANT Evelyn C. Frank, 1003 Southwick Ct. 21204										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden		
DUE TO, OR AS A CONSEQUENCE OF (b) CVA								3+/- yrs.		
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD								9+/- yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Sept 5 19 78 to Oct 19 19 87 , that (I) (we) lost saw the deceased alive on Oct 17 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) had not view the body after death.										
22b. SIGNATURE <i>Charles F. O'Donnell</i>						DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/19/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. O'Donnell, M.D.						22e. ADDRESS 7501 York Rd. Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 23, 1987		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Overlea Balto., Md.			
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, Md. 21214						25. DATE RECEIVED BY REGISTRAR OCT 22 1987				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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October 1, 1952

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at 10:00
at 1:00

United-Republics Airlines

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10 - 17-1802

10/1/52

Charles E. Donnell, Jr., 101 York St., New York, N.Y.

10/1/52



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA MARY MEKOLON			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 29, 1987		2b. HOUR 4:20 A.M.	
3 SEX FEMALE	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 - 21 - 07		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Co. MD.		

10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN NURSING CTR - Heritage Housewife	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) own home	12b. KIND OF BUSINESS OR INDUSTRY
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13a. STATE MD.		13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1727 RANDOLPH Ave. 21222
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14 FATHER'S NAME FIRST MIDDLE LAST Jacob Niemczyk		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Schneider	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 313-07-5914	17 INFORMANT ADDRESS Lillian Collier 2306 Lodge Farm Rd. 21219
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18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) RECURRENT PNEUMONIA	5 years. 2 years.
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): RHEUMATOID ARTHRITIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (I) (this hospital) attended the deceased from 9/20/85 to 10/29/87 that (I) (we) lost the deceased alive on 10/29/87 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Harjit Singh	DEGREE MD.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/29/87
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARJIT SINGH M.D.	22e. ADDRESS 5507-E RITCHIE HWY, BALTIMORE MD. 21225
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11-2-87	23c. NAME OF CEMETERY OR CREMATORY Christ Lutheran	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
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24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222	25a. DATE REC'D. BY REGISTRAR NOV 03 1987	25b. REGISTRAR'S SIGNATURE Julia Swenson-Rudner
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

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068101 OCT-87

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 28185			
FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLADYS CECELIA MELLOTT						2a. DATE OF DEATH MONTH DAY YEAR October 4, 1987				2b. HOUR 12 ⁵⁰ P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 8 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 711 Maiden Choice Apt. 2304				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Apt. 2304 711 Maiden Choice Lane 21228					
14. FATHER'S NAME FIRST MIDDLE LAST Lewis R. Springer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena E. Adams									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-14-9358		17. INFORMANT ADDRESS Edward E. Mellott 802 Lee Ave. 21784									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adenocarcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Cigarette Use</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Left Pleural Effusion and Atelectasis Left Lung 2° #2 Chronic Bronchitis</u>													
20. 3. DATE OF OPERATION													
21. 4. CONDITION FOR WHICH OPERATION WAS PERFORMED													
22. 5. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
23. 6. IF ALLOWED BY LAW, IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) St. Agnes Hospice				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 85, to October 4, 19 87, that (I) (we) last saw the deceased alive on 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dennis M. Smith				DEGREE M.D., ATTENDING PHYSICIAN				22c. DATE SIGNED 10-4-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS M. SMITH M.D.				22e. ADDRESS 3455 WILKENS AVE ST. AGNES MEDICAL CENTER BALTO, MD. 21229									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/7/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland							
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						25a. DATE REC'D. BY REGISTRAR OCT 06 1987		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body. Page 4 should be retained by the funeral director. The medical examiner's report, if any, should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified of cause.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

[Faint, mostly illegible text covering the majority of the page, appearing to be a list or ledger with multiple columns.]

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069206 OCT 27

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lillian A. MENKEL			2a. DATE OF DEATH MONTH DAY YEAR 10/16/87			2b. HOUR 1:36 A M			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 6 19 20		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTO. County MD			
12. CITY OR TOWN OF DEATH Towson		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Packer-American Can		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN			17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE Balto., Md. 1718 Selma Ave. #21227				
19. FATHER'S NAME FIRST MIDDLE LAST Frederick E. Menkel			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie S. Jones						
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			22. SOCIAL SECURITY NO. 214 182628		23. INFORMANT ADDRESS 5113 S. Rolling Rd. - Balto., Md. Mr. Johnnie W. Menkel #21227				
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PANCREATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Colorectal cancer									
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED				26a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
28a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		28c. LOCATION STREET CITY OR TOWN COUNTY STATE					
29. I certify that (I) (this hospital) attended the deceased from 9/28 , 19 87 , to 10/16 , 19 87 , that (I) <input checked="" type="radio"/> saw the deceased alive on 10/16 , 19 87 , and that in (my) <input checked="" type="radio"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="radio"/> did not view the body after death.									
29a. SIGNATURE Carla S. Alexander				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		29c. DATE SIGNED 10/16/87	
29d. PHYSICIAN'S NAME (TYPE OR PRINT) Carla S. Alexander, M.D.				29e. ADDRESS Stella Maris Hospice Dulaney Valley Rd. - Towson, MD 21204					
30a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		30b. DATE Oct. 19, 1987		30c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		30d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
31. FUNERAL DIRECTOR G. L. Schwab				31a. ADDRESS 5151 Balto. Nat'l. Pike #21229		31b. DATE REC'D. BY REGISTRAR OCT 30 1987		31c. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Esther Kate Merchant					2a. DATE OF DEATH MONTH DAY YEAR 10 17 87			2b. HOUR 9:20 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 24, 1895		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 91		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7200 Third Ave. 21384			
14. FATHER'S NAME FIRST MIDDLE LAST Lewis Washington McDonald					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leila H. Kennon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213 38 9800		17. INFORMANT ADDRESS Fairhaven, Inc. Sykesville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Failure DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edmund P. Trzask					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10/17/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDMUND P. TRZASK					22e. ADDRESS Balt. Cty. GENERAL Hospital						
23a. BURIAL, CREMATION, REMOVAL (SP. BY) Burial			23b. DATE 10-21-87		23c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery			23d. LOCATION (CITY OR TOWN) COUNTY STATE Chickestown Allegany Va.			
24. FUNERAL DIRECTOR NAME Harry W. Haight					ADDRESS Sykesville, Md.			DATE PROC. BY CLERK OCT 20 1987			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 2 8 1 8 8

FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) CATHERINE ROSE O'HEARNE MEREDITH		2a DATE OF DEATH MONTH 10 DAY 13 YEAR 87		2b HOUR 11:25 P.M.	
3 SEX F Female	4 RACE Caucasian W	5 DATE OF BIRTH MONTH 01 DAY 04 YEAR 29		6 AGE (IN YEARS LAST BIRTHDAY) 58	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Spring Grove Hospital Cen.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Spring Grove Hospital Cen.		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE MD		13b COUNTY P. Georges Silver Hill		13c CITY OR TOWN Elkton, VA	
14 FATHER'S NAME FIRST John MIDDLE Joseph LAST O'Hearne		15 MOTHER'S MAIDEN NAME FIRST Norma MIDDLE Ford LAST Ford		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A	
16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT Elkton, VA ADDRESS 22827		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic PULMONARY CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic PULMONARY CARCINOMA	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE John Stern		DEGREE		22c DATE SIGNED 10-13-87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) John Stern		22e ADDRESS Spring Grove Hospital Center		22f ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10-17-87		23c NAME OF CEMETERY OR CREMATORY Elk Run Cemetery	
23d LOCATION CITY OR TOWN Elkton, Rockingham, VA		23e STATE VA		23f DATE REC'D. BY REGISTRAR OCT 20 1987	
24 FUNERAL DIRECTOR NAME MacNabb F.H. Catonsville, MD		24b REGISTRAR'S SIGNATURE Julia Davidson-Randall		24c ADDRESS 22980	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP



70441 NOV-28

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 28187

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Otto Meyer			2a. DATE OF DEATH MONTH DAY YEAR 10/29/87			2b. HOUR 9:15 a.m.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 25, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CATONSVILLE MERIDIAN CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY STEEL MFG.		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1323 WESTBURN ROAD 21228	
14. FATHER'S NAME OTTO MEYER			15. MOTHER'S MAIDEN NAME FRIEDE WOLF							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-09-2053		17. INFORMANT MRS. JOAN GOUDY					
					2008 FERN GLEN WAY CATONSVILLE, MD. 21228					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Internal Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Dis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>yes</u> <u>yes</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Depression</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-30</u> , 19 <u>85</u> , to <u>10-29</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>E. H. Weiss</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. H. Weiss</u>			22e. ADDRESS <u>606 Hammond Lane - 21225</u>							
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 10/31/87		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK		23d. LOCATION WOODLAWN COUNTY MARYLAND			
24. FUNERAL DIRECTOR LEROY L. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228					25a. DATE REC'D. BY REGISTRAR OCT 30 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Benner-Rodriguez</u>			

MEDICAL CERTIFICATION

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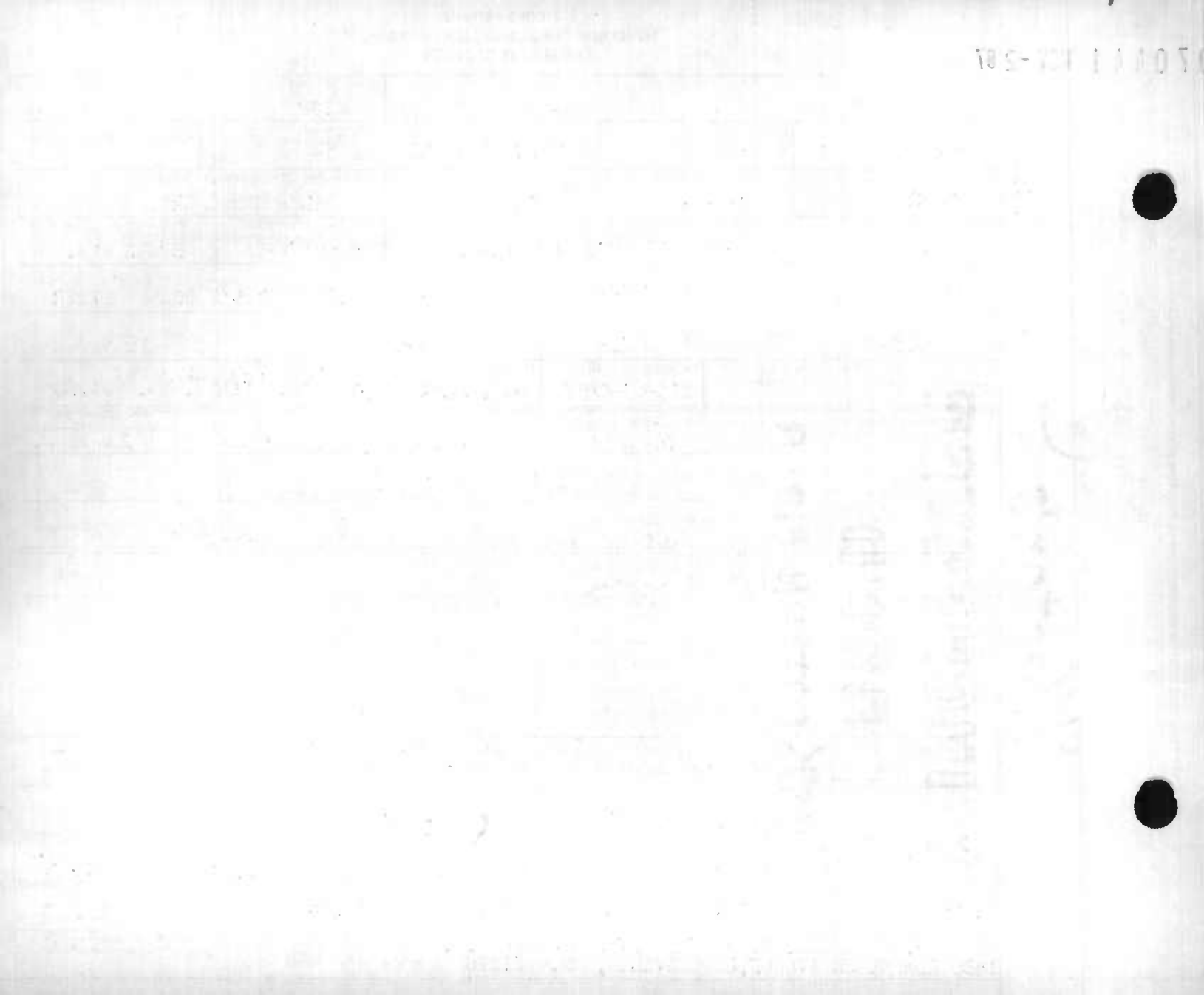
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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BP



068472 OCT 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John R. Meyers Jr.			2a. DATE OF DEATH MONTH DAY YEAR Oct. 11, 1987			2b. HOUR 12:30A.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co.		
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. Gen. Hospt.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Minister		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John R. Meyers Sr.				15. MOTHER'S MAIDEN NAME MIDDLE LAST Elsie S. Campbell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1945		17. INFORMANT ADDRESS Mrs. Doris B. Meyers Owings Mills, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic prostate cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Feb 18, 1987 to 9/26, 1987 , that (we) lost saw the deceased alive 9/16, 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (if we) (did) (did not) view the body after death.								
22b. SIGNATURE [Signature]				DEGREE MD		22c. DATE SIGNED 10/12/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 10/12/87		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead, Md.		
24. FUNERAL DIRECTOR NAME Eline Funeral Home Reisterstown, Md. 21136				25a. DATE REC'D. BY REGISTRAR OCT 13 1987		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

08435 OCT 14 67

NOT RECORDED
FILED
OCT 14 1967

10/11/67

X

08435 OCT 14 1967

068658 OCT 58

58
OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Katherine L. MILLER			2a. DATE OF DEATH MONTH DAY YEAR October 10, 1987		2b. HOUR 8:30P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 6, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Cafe
13a. STATE Maryland		13b. COUNTY --	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4923 Schaub Ave, 21206
14. FATHER'S NAME FIRST MIDDLE LAST James Gerben			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Alman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS A Ralph H. Miller, husband, same as above	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia		
DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute Renal Failure			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from September 22, 1987, to October 10, 1987, that (we) lost saw the deceased alive on October 10, 1987, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Howard Goldman MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/10/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Goldman MD.		22e. ADDRESS 9000 Franklin Square Drive 21237	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/14/87	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, Balto, Md. 21218		25a. DATE REC'D. BY REGISTRAR OCT 14 1987	
25b. REGISTRAR'S SIGNATURE Julia Dendron-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROSE MILLER			2a. DATE OF DEATH MONTH DAY YEAR 10 05 87		2b. HOUR 7:15 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 04 99	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE
13a. STATE Maryland	13b. COUNTY XXXXXXXXXX	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6000 20E Park Heights 21205	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS MILLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA FINE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-44-9320		17. INFORMANT MR. MERVIN SHPRITZ APT. 6 3201 OLD POST DR. BALTO., MD 21208	

18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours
DUE TO, OR AS A CONSEQUENCE OF (b) Alters Deostic Cardiovascular Disease		year
DUE TO, OR AS A CONSEQUENCE OF (c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Senile Dementia Hypothyroidism		

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10 5 19 87 to 10 5 19 87 , that (I) (we) last saw the deceased alive on 10 5 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)			
22b. SIGNATURE Frederic H. Copeland MD	DEGREE MD	22c. DATE SIGNED 10/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Copeland MD		22e. ADDRESS 8620 Liberty Plaza Mall Randallstown MD 21133	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE OCT. 7, 1987	23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR OCT 08 1987	25b. REGISTRAR'S SIGNATURE Frederic H. Copeland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

067904 OCT

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

35238-193

1. DECEASED NAME (TYPE OR PRINT) Grace Elizabeth Moore			2a. DATE OF DEATH MONTH DAY YEAR 10/4/87			2b. HOUR 6:15 P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-30-03		6. AGE (YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET AND CITY) St. Joseph's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN White Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Moore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Levina Ellen Grant			13e. STREET ADDRESS / ZIP CODE 2014 White Hall Rd. 21161			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-38-5576		17. INFORMANT ADDRESS Mrs. Edith M. Preston 415 Monkton Rd 21111				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) renal failure DUE TO, OR AS A CONSEQUENCE OF (b) colon cancer - metastatic DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Schuchter			DEGREE			22c. DATE SIGNED 10/4/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Schuchter			22e. ADDRESS St Joseph Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-7-87		23c. NAME OF CEMETERY OR CREMATORY Vernons United Meth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE White Hall Balto. Md.		
24. FUNERAL DIRECTOR NAME Martin D. Lawson			10 W. Padonia Rd.			25. DATE REC'D BY REGISTRAR OCT 07 1987			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place in separate coffin papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP _____

081800 OCT 8 81

28

OCT 07 1981

1. DECEASED NAME (TYPE OR PRINT) Arthur Peter Mossner			2a. DATE OF DEATH MONTH DAY YEAR Oct. 16, 1987		2b. HOUR 7:00 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1924		
6. AGE (IN YEARS LAST BIRTHDAY) 63		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		
12. CITY OR TOWN OF DEATH Randallstown		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3451 Carriage Hill Circle		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Md.		15b. COUNTY Balto.		15c. CITY OR TOWN Randallstown		
16. FATHER'S NAME FIRST MIDDLE LAST Arthur Mossner		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Brady				
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. 133-16-4653		19. INFORMANT Claire J. Mossner 3451 Carriage Hill Circle Randallstown, Md. 21133		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accute Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Severe ASCVD, Arythmias, Congestive Heart Failure						
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
23a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		23c. LOCATION STREET CITY OR TOWN COUNTY STATE		
24. I certify that (I) (this hospital) attended the deceased from March 19 75 to Oct 19 87 , that (I) (we) lost saw the deceased alive on Oct 14 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
25. SIGNATURE JAY STEPHEN MARGOLIS		DEGREE M.D.P.A.		26. DATE SIGNED 10/19/87		
27. PHYSICIAN'S NAME (TYPE OR PRINT) JAY STEPHEN MARGOLIS, M.D.P.A.		28. ADDRESS 70 F Painters Mill Road Owings Mills, 21117				
29a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		29b. DATE Oct. 19, 1987		29c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		
30. FUNERAL DIRECTOR NAME H. J. Zehhardt		ADDRESS Owings Mills, Md.		31. DATE RECEIVED BY REGISTRAR OCT 20 1987		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove companion pages 1 and 2 and send them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified for notification of death.

BP

0350 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE M. MUNDT			2a. DATE OF DEATH MONTH DAY YEAR Oct. 1, 1987		2b. HOUR 7:40 P				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 - 26 - 01		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DULANEY - TOWSON NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7822 1/2 Highpoint Rd. 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Peter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Repp						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-05-4147		17. INFORMANT ADDRESS Marie E. Wirth 7822 1/2 Highpoint Rd. 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Senile dementia-aphasia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/8/87, 19 77, to 9/14, 19 87, that (I) (we) last saw the deceased alive on 9/14, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald O. Wood				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD O. WOOD, M.D.				22e. ADDRESS 2 Greenmeadow Dr., Timonium, MD 21093					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-5-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Overlea Baltimore md.			
24. FUNERAL DIRECTOR NAME Hartley Miller				ADDRESS 7527 Harford Rd		25a. DATE REC'D. BY REGISTRAR OCT 5 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson	

BP

087030 OCT-88



1



068475 OCT 14 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2810

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jacob Munz

2a. DATE OF DEATH MONTH DAY YEAR Oct 8 1987

2b. HOUR 11 A.M.

3. SEX Male

4. RACE White

5. DATE OF BIRTH MONTH DAY YEAR 6 1 1905

6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.

10. CITY OR TOWN OF DEATH Pikesville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Jewish Convalescent Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier

12b. KIND OF BUSINESS OR INDUSTRY Restaurant

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY 13d. CITY OR TOWN Baltimore 13e. INSIDE CITY LIMITS? YES ☒ NO ☐ 13f. STREET ADDRESS / ZIP CODE 404 N. PACA ST 21201

14. FATHER'S NAME FIRST MIDDLE LAST Solomon Munz

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Waldman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No

16b. SOCIAL SECURITY NO. 217-07-0306

17. INFORMANT ADDRESS Sandy Winakur - 4 Sutherland Ct - 21208

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION (probable)
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. ARTERIOSCLEROSIS - GENERALIZED, ADVANCED

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/24 87 to 10/8 87, that (I) saw the deceased alive on 10/5/87, and that in my opinion death occurred on the date and hour and from the causes stated above. (If the individual died prior to the body after death)

22b. SIGNATURE Dr. Sunthine, MD DEGREE

22c. DATE SIGNED 10/9/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 100 SUNTHINE, MD ADDRESS 6210 PARK HTS AVE BALT, MD 21215

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 10/11/87

23c. NAME OF CEMETERY OR CREMATORY Mikro Kodesh

23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland

24. FUNERAL DIRECTOR NAME ADDRESS 21208 Hebrew Memorial F.H. - 1100 Reisterstown Rd

25a. DATE REC'D. BY REGISTRAR OCT 13 1987

25b. REGISTRAR'S SIGNATURE Julia Gordon-Kendall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. The funeral director should be detached for use as the burial transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRS 15, 4)

08 OCT 1987

069991 OCT 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 2819

REG. NO.

FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Vera

M.

Murphy

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

10

15

87

1:10 AM

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

7TH13^{DAY}1913^R

6. AGE (IN YEARS (LAST BIRTHDAY))

74

YRS.

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN)

Ohio

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8

MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

MD.

10. CITY OR TOWN OF DEATH

Baynesville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Meridian Cromwell Nursing Home

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR

INDUSTRY

Home

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

Maryland

13c. COUNTY

Balto.

13d. CITY OR TOWN

Timonium

13e. INSIDE CITY LIMITS?

YES ☐ NO ☒

13f. STREET ADDRESS / ZIP CODE

7806 Elmerhurst Ave. 21234

14. FATHER'S NAME

FIRST

John

MIDDLE

D.

LAST

Stone

15. MOTHER'S MAIDEN NAME

FIRST

Maida

MIDDLE

Pearl

LAST

Clark

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

162-42-5613

17. INFORMANT

ADDRESS

Mrs. Roberta Schnepsfe 2424 Chetwood Circle 21093

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Sementra

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last

saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Marion C. Kowalewski

DEGREE

M.D.

ATTENDING

PHYSICIAN ☒

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☐

22c. DATE SIGNED

10-15-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Marion C. Kowalewski M.D.

22e. ADDRESS

8604 Harford Rd. 21234

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

10/19/87

23c. NAME OF CEMETERY OR CREMATORY

Union Cemetery

23d. LOCATION

Uhrichsville Tuscarawas Ohio

24. FUNERAL DIRECTOR

NAME

Ruek Towson Funeral Home, Inc.

ADDRESS

1050 York Rd.

21204

25a. DATE REC'D. BY REGISTRAR

OCT 31 1987

25b. REGISTRAR'S SIGNATURE

Julia Fisher-Rudner

19 05 130 1 8 2 2 3 0

70737 NOV -4 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas J. Murphy			2a. DATE OF DEATH MONTH DAY YEAR 10 30 87			2b. HOUR 11:33a M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 10 1909		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Director of Civil Serv. Comm.		12b. KIND OF BUSINESS OR INDUSTRY Balto. City	
13a. STATE Maryland		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 200 Stanmore Rd., 21212	
14. FATHER'S NAME FIRST MIDDLE LAST James William Murphy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Theresa Helfyar					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Norberta M. Fath, 1 Broester Ct., 21131					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) End-Stage Liver Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: -									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from October 27, 19 87 , to October 30, 19 87 , that (I) (we) last saw the deceased alive on October 30, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Allan E. Frankle MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allan E. Frankle, M.D.					22e. ADDRESS G.B.M.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/3/87		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gardens			23d. LOCATION CITY OR TOWN COUNTY Timonium Balto. Md.	
24. FUNERAL DIRECTOR Martin D. Lawson					25a. DATE REC'D. BY REGISTRAR 11-2-87		25b. REGISTRAR'S SIGNATURE		
ADDRESS Martin D. Lawson, 10 W. Padonia Rd.									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMM - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be circulated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EUGENE K MYERS				2a. DATE OF DEATH MONTH DAY YEAR 10-5-87				2b. HOUR 4:10 A.M.	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 5 30 25		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 10 5	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore Co. MD.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. Gen. H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpentry		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Carroll 13c. CITY OR TOWN Westminster				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 524 Morelock Schoolhouse Rd. 21157			
14. FATHER'S NAME FIRST MIDDLE LAST C. Otto Myers Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie P. Hively		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 163-24-8223		17. INFORMANT Catherine B. Myers ADDRESS 130 21157	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). CA OF THE ESOPHAGUS DUE TO, OR AS A CONSEQUENCE OF (b). S/P LEFT PNEUMONECTOMY FOR CA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-14 , 19 87 , to 10-5 , 19 87 , that (I) (we) last saw the deceased alive on 10-5 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE		22c. DATE SIGNED 10-5-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. CONANAN MD				22e. ADDRESS 206H RANDALLSTOWN Rd. 21133					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-8-87		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md			
24. FUNERAL DIRECTOR Robert Kyle Pritts Westminster Md, 21157				25a. DATE REC'D. BY REGISTRAR OCT 13 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall			

69528 OCT 23 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
PETER		C.		MYERS				10-15-87								M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male		Black		Jan. 16, 1960		27 YRS.						10-15-87								6:03a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
Maryland		USA				Baltimore County															
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS															
Randallstown		Baltimore County General Hospital		Delivery Superv.		Villa Hts. Services															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD		Howard		Columbia		YES <input type="checkbox"/> NO <input type="checkbox"/>		8042 Guilford Road/												21044	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST											
Leroy Myers		Mary Askins																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
No				Mary Myers (mother)		same as #13															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) Pulmonary thromboembolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Earl R. Nalley</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 2 87</i>		2b. HOUR <i>6:37 AM</i>		
3. SEX <i>M</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>04/09/33</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>54</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>U.S.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2 Friendship Circle Baltimore</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>unemployed</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ernest Nalley</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Coeta Winagreen</i>		13e. STREET ADDRESS / ZIP CODE <i>2 Friendship Cir. 21202</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>214 28 4791</i>		17. INFORMANT <i>MD. V.A. Hospital</i>		ADDRESS <i>Loch Raven Blvd</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>COPD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>35 min.</i> <i>yrs.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>pneumonia chronic period schizophrenia, DM</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/22</i> , 19 <i>87</i> , to <i>10/2</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>10/1</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Doris B. Strader MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>10/2/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DORIS B. STRADER MD</i>				22e. ADDRESS <i>Loch Raven V.A.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/14/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Crownsville Veterans</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Crownsville MD</i>	
24. FUNERAL DIRECTOR NAME <i>Sharon Carroll</i>				ADDRESS <i>1712-14th North Ave</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 7 1987</i>	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Sam M. Nance			2a. DATE OF DEATH MONTH DAY YEAR October 18, 1987		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 9 6 1948	6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD		
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore Co. General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9828 Tolworth Circle 21133	
14. FATHER'S NAME FIRST MIDDLE LAST Sam Nance		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Hardy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 099-40-6956		17. INFORMANT ADDRESS Tawanta Nance 9828 Tolworth Circle	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Squamous Cell Cancer DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that this hospital attended the deceased from Aug 19 86 to Oct 19 87, that (I) (we) last saw the deceased alive on Oct 14 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DON A. STEVENS		22c. ADDRESS 601 N. W. Ne St. Balt MD 21205		22d. DATE SIGNED 10/20/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/23/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY Md		23f. STATE	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		24b. ADDRESS 4300 Wabash Avenue		25. DATE REC'D BY REGISTRAR OCT 23 1987	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE M. NEUBAUER			2a DATE OF DEATH MONTH DAY YEAR October 15, 1987		2b HOUR 12:45AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR December 25, 1896		
6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Home		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY				
13a STATE Maryland		13b CITY OR TOWN Baltimore		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13d STREET ADDRESS / ZIP CODE 1443 Cedar Croft Rd. 21239		14 FATHER'S NAME FIRST MIDDLE LAST Not Known Borgman		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 213-74-1422		17 INFORMANT ADDRESS Pamela Neubauer 5616 Rimmell Ave. 21206		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Urinary Tract DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		21g I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22a SIGNATURE DEGREE Dr. Celar E. Parra M.D.		
22b SIGNATURE Dr. Celar E. Parra		22c DATE SIGNED 1/15/88		22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Celar E. Parra		
22e ADDRESS 7122 Harford Road Baltimore, Maryland		23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Oct 17 1987		
23c NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.		
24 ADDRESS Baltimore, Maryland		25a DATE REC'D. BY REGISTRAR OCT 21 1987		25b REGISTRAR'S SIGNATURE		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
James A. Nichols				10/9/87		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male	Caucasian	11/8/14		72 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.			Baltimore County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown	Baltimore County General Hospital			Restauranter		Self employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Baltimore		Reisterstown	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
E. John Nichols				Imma H. Hooper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		215-12-5964		Mrs. Lillian Nichols			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC CARDIOMYOPATHY</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC CONGESTIVE HEART FAILURE</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>10-60</u> to <u>10-1</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT)				22c. DATE SIGNED			
Dr. Samuel Scalia				10-11-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
				2 Church Lane Baltimore 21208			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10/12/87		David Ridge Cemetery		Pikesville Baltimore MD	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Loring Byers Funeral Directors, Inc				OCT 13 1987		Julia Davidson-Randall	
8728 Liberty Road Randallstown Maryland 21133							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, accident, or other traumatic event, the medical examiner should be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Katharine E Noel			20. DATE OF DEATH MONTH DAY YEAR 10 25 87		2b. HOUR 1055 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 16 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. City	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County Gen. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Owings Mills	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Wagner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Look			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-54-2802		17. INFORMANT Walter A. Bosley	
				ADDRESS Owings Mills 21117	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). DUE TO, OR AS A CONSEQUENCE OF (c). PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c). <u>Nurse</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> , 19 <u>87</u> , to <u>10/25</u> , 19 <u>87</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>10/25</u> , 19 <u>87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If not, state date and hour and from the causes stated.) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) E. Charles A. [Signature]		22c. DATE SIGNED 10 25 87		22d. ADDRESS Balto. County General Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-28-1987		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial	
23d. LOCATION CITY OR TOWN Finksburg		23e. COUNTY Carroll		23f. STATE Md.	
24. FUNERAL DIRECTOR Eline Funeral Home Reisterstown #21136				25a. DATE REC'D BY REGISTRAR OCT 27 1987	
				25b. REGISTRAR'S SIGNATURE Julia Dondan-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) William James NOLAN Jr.			2a. DATE OF DEATH MONTH DAY YEAR October 19 1987			2b. HOUR 9:00a M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 2, 1915			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hos.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. U.S.D. of Labor			12b. KIND OF BUSINESS OR INDUSTRY OSHA Inspector				
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 611 Joppa Farm rd. 21085		
14. FATHER'S NAME FIRST MIDDLE LAST William J. nolan Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Macdonald			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) U.S.C.G. Yes 1942			16b. SOCIAL SECURITY NO. 063-03-5280			
17. INFORMANT Mrs. Anne A. Nolan, Joppa, Md. 21085			17. ADDRESS 611 Joppa Farm Rd.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 16, 1987 , to October 19, 1987 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 19, 1987 , and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE James Bloomer M.D.						DEGREE MD		22c. DATE SIGNED 10/19/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Bloomer, M.D.						22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-22-1987		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rosedale Balto. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087						25a. DATE REC'D. BY REGISTRAR OCT 23 1987		25b. REGISTRAR'S SIGNATURE David R. Riddle				

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TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be retained by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 87 28207	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) RUTH C NORFOLK			20. DATE OF DEATH MONTH DAY YEAR 10 2 87		2b. HOUR 840 P.M.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 3 4 93		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY Baltimore	13c. CITY OR TOWN RANDALLSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3831 CASSANDRA RD 21133	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Wood			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Mae Dean		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-03-5923D		17. INFORMANT ADDRESS Mr. Leroy Norfolk 21133 3831 Cassandra Road Randallstown, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <div style="display: inline-block; vertical-align: middle;"> (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) </div>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9-27 , 19 87 , to 10/2 , 19 87 , that (I) (we) lost saw the deceased alive on 10/2 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael E. Collier, M.D.		DEGREE M.D.		22c. DATE SIGNED 11/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. COLLIER, M.D.		22e. ADDRESS 5401 OLD CT. RD. RANDALLSTOWN, MD 21133			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/6/87	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland		
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.			25a. DATE REC'D. BY REGISTRAR OCT 06 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall
8728 Liberty Road Randallstown, MD. 21133					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy M Norris			2a. DATE OF DEATH MONTH DAY YEAR Mon. 10 26 87		2b. HOUR 8:06 AM
3 SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR NOV. 16, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? US OF A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN RANDALLSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3705 NORRIS AVE. 21133	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES HODGE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY NELSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214 20 9938A		17. INFORMANT ADDRESS MR. GREGORY NORRIS 3705 NORRIS AVE 21133	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Fa. lunc DUE TO, OR AS A CONSEQUENCE OF (b) RENAL Fa. lunc DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Colon Cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edmund P. Tkachuk		DEGREE MD		22c. DATE SIGNED 10/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10/31/87	23c. NAME OF CEMETERY OR CREMATORY ST. THOMAS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY RANDALLSTOWN (BALTO.) MD.	
24. FUNERAL DIRECTOR NAME ADDRESS LEWIS T. GWYNN 4517 PARK HEIGHTS AVE. 21215			25a. DATE REC'D. BY REGISTRAR OCT 28 1987	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

7 8 2 3 5 0 1 2 3 4

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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068396 OCT 14 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Pages 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jerome Francis Noyes		2a. DATE OF DEATH MONTH DAY YEAR 10-11-87		2b. HOUR M 10	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 4-10-04		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH COUNTY Balto. Co. MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVERVIEW NURSING CENTRE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Rice Bakery
13a. STATE MD.		13b. COUNTY Baltimore	13c. CITY OR TOWN Eastpoint	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSHUA NOYES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLOTTE ROBERT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-22-5162		17. INFORMANT ADDRESS Catherine R. Noyes 8039 Wynbrook Rd. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Coronary Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic Destructive Pulmonary Disease, cerebrovascular accident.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael Schwartz MD				22c. DATE SIGNED 10-12-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Schwartz MD				22e. ADDRESS 606 Homewood Lane	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-14-87		23c. NAME OF CEMETERY OR CREMATORY Holy Cross	
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn, A.A. Co., Md.		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.		ADDRESS 6224 Eastern Ave.		25. REGISTRAR'S SIGNATURE Oct 13 1987	

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                     |                                                                                                                                                             |                                                                                                 |                                                                                          |                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIRGINIA ADAMS OBRIEN</b>                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 15 87</b>                                          |                                                                                          | 2b. HOUR<br><b>6:00PM</b>                                     |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br><b>White</b>                                                                                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 09 1915</b>                                                                                                     |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>72</b>                         |                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>                       |                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N. CHARLES STREET G.B.M.C.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b>           |                                                                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Stewart &amp; Co.</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                     | 13c. CITY OR TOWN<br><b>Cockeysville</b>                                                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>8 St. Elmo Ct. apt. 102 21030 Cockeysville, MD.</b> |                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edwin W. Adams</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Grace Burkhardt</b>                                                                                     |                                                                                                 |                                                                                          |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                             |                                                                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>220-01-5484</b>                                                                                                              |                                                                                                 | 17. INFORMANT<br>ADDRESS<br><b>John Gordon O'Brien same as 13e</b>                       |                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ABDOMINAL CARCINOMATOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last. |                                                                                                                                                     |                                                                                                                                                             |                                                                                                 |                                                                                          |                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                    |                                                                                                                                                     |                                                                                                                                                             |                                                                                                 |                                                                                          |                                                               |
| 19a. DATE OF OPERATION<br><b>10-14-87</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>SMALL INTESTINAL OBSTRUCTION</b>                                                                     |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |                                                               |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                |                                                                                                                                                     | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |                                                                                                 |                                                                                          |                                                               |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                              |                                                                                                 |                                                                                          |                                                               |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |                                                                                                                                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>10/12 87 10/15 87</b>            |                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/12 87</b> , to <b>10/15 87</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                               |                                                                                                                                                     |                                                                                                                                                             |                                                                                                 |                                                                                          |                                                               |
| 22b. SIGNATURE<br><b>P. Patel</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |                                                                                                 | 22c. DATE SIGNED                                                                         |                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. P.J. PATEL</b>                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                     | 22e. ADDRESS<br><b>G.B.M.C., 6701 N. CHARLES ST., 21204</b>                                                                                                 |                                                                                                 |                                                                                          |                                                               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                     | 23b. DATE<br><b>Oct. 17, 1987</b>                                                                                                                           |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Crematory</b>                        |                                                               |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Maryland</b>                                                                                                                                                                                                                                                                                                              |                                                                                                                                                     | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Walter Brooks Bradley Inc. Dundalk, MD. 21222</b>                                                                |                                                                                                 |                                                                                          |                                                               |
| 25a. DATE REC'D. BY REGISTRAR                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>OCT 19 1987 Julia [Signature]</b>                                                                                          |                                                                                                 |                                                                                          |                                                               |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 2821

FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                              |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                   |  |                                                   |  |
|------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|---------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA</b>                              |  | FIRST <b>M.</b>                                                                                                                                      |  | MIDDLE <b>O'NEIL</b>                                                                                                                                        |  | LAST                                                                                            |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>28</b> YEAR <b>87</b> |  | 2b. HOUR <b>8:55</b> PM                           |  |
| 3. SEX<br><b>FEMALE</b>                                                      |  | 4. RACE<br><b>White</b>                                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>25</b> YEAR <b>00</b>                                                                                             |  | 6. AGE, IN YEARS LAST BIRTHDAY<br><b>87</b>                                                     |  | IF UNDER 1 YEAR<br>MONTHS <b>8</b> DAYS <b>7</b>                  |  | IF UNDER 24 HRS.<br>HOURS <b>8</b> MIN. <b>55</b> |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>BALto, md</b>             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                             |  |                                                                   |  |                                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>DUNDALK, md</b>                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Heritage Nursing Center</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>                  |  |                                                   |  |
| 13a. STATE<br><b>md</b>                                                      |  | 13b. COUNTY<br><b>N</b>                                                                                                                              |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>247 S. Conkling St 21224</b> |  |                                                   |  |
| 14. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Stehr</b> LAST <b>Stehr</b> |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>John</b> MIDDLE <b>Stehr</b> LAST <b>Stehr</b>                                                                  |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                   |  |                                                   |  |

|                                                                                |  |                                                |  |                                                              |  |         |  |
|--------------------------------------------------------------------------------|--|------------------------------------------------|--|--------------------------------------------------------------|--|---------|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>214-18-0915</b> |  | 17. INFORMANT<br><b>Murrill Long, 7863 Kentley Rd. 21222</b> |  | ADDRESS |  |
|--------------------------------------------------------------------------------|--|------------------------------------------------|--|--------------------------------------------------------------|--|---------|--|

|                                                                                                                                                                                                                                                                                                           |  |                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Secondary to Bronchitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Alzheimer's Disease</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|                                                                                                                                                          |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                               |  |

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

|                                                                        |  |                                                       |  |                                     |  |
|------------------------------------------------------------------------|--|-------------------------------------------------------|--|-------------------------------------|--|
| 22b. SIGNATURE<br><b>Willard A. Edwards</b>                            |  | DEGREE                                                |  | 22c. DATE SIGNED<br><b>10/28/87</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WILLARDA EDWARDS, M.D.</b> |  | 22e. ADDRESS<br><b>1401 N. LAKEWOOD AVE BALto, md</b> |  |                                     |  |

|                                                            |  |                              |  |                                                                |  |                                                                        |  |
|------------------------------------------------------------|--|------------------------------|--|----------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b> |  | 23b. DATE<br><b>10/31/87</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b> STATE |  |
|------------------------------------------------------------|--|------------------------------|--|----------------------------------------------------------------|--|------------------------------------------------------------------------|--|

|                                                                            |  |                      |  |                                                     |  |                                                           |  |
|----------------------------------------------------------------------------|--|----------------------|--|-----------------------------------------------------|--|-----------------------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br>NAME <b>Joseph N. Zannino, 263 S. Conkling St.</b> |  | ADDRESS <b>21224</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 02 1987</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Gordon-Randall</b> |  |
|----------------------------------------------------------------------------|--|----------------------|--|-----------------------------------------------------|--|-----------------------------------------------------------|--|

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                                      |                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Donald George Orem, Jr.                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                               |                                                                        | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>10/ 9/ 87                                                                                         |                                                                                                                      | 2b. HOUR<br>M<br>3:00<br>a M                                                        |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br>white                                                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03-16-1960                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>27 YRS.                                                                                                                  | 7. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10/ 9/ 87                                                               | 7b. HOUR<br>M<br>3:00<br>a M                                                        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD                        |
| 10. CITY OR TOWN OF DEATH<br>Sparrow's Point                                                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bethlehem Blvd. |                                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Heavy Eqp. Operator                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction Co.                               |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                              |                                                                                                                               |                                                                        | 13b. CITY OR TOWN<br>Allegany                                                                                                                               | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      | 13d. STREET ADDRESS<br>none/21532                                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Donald Orem                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                               |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara Granger                                                                                            |                                                                                                                      |                                                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>214-76-6792                                |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>Mrs. Tammy M. Orem, Flintstone, MD-wife                                                  |                                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                             |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                               |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                                      |                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |                                                                                                                                                             |                                                                                                                      | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                   |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>2:14pm 10/ 9/ 87    |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver of auto/fire truck collision |                                                                                     |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                |                                                                                                                               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>roadway |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Bethlehem Blvd. Sparrow's Point, Balto. Co., MD                 |                                                                                     |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                                                                                                               |                                                                        |                                                                                                                                                             |                                                                                                                      |                                                                                     |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                               | TITLE (SPECIFY)<br>Assistant                                           |                                                                                                                                                             | DATE SIGNED<br>10/9/87                                                                                               |                                                                                     |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                               | ADDRESS<br>111 Penn St., Balto., Md. 21201                             |                                                                                                                                                             |                                                                                                                      |                                                                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                               | 23b. DATE<br>10-12-1987                                                |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Sunset Memorial Park                                                           |                                                                                     |
| 24. FUNERAL DIRECTOR<br>NAME<br>James F. Scarpelli, Cumberland, MD 21502                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cumberland Allegany MD   |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>10/14/1987                                                                          |                                                                                     |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ADVISE THE CHIEF MEDICAL EXAMINER WITH FORM PM-5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                       |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                            |  |                                                                                      |                              | REG. NO.                                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JEROME THOMAS ORTT</b>                                                                                                                                                                                                                                         |  |                                                                                                                                                      |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 6, 1987</b>                                                 |  |                                                                                      | 2b. HOUR<br><b>6:05 p.m.</b> |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br><b>C White</b>                                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 8 1928</b>                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS                                                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                      |                              | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>                                                                            |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                                        |  |                                                                                      |                              |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Policeman</b>                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Law Enforcement</b>                          |                              |                                                                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                      |  | 13c. CITY OR TOWN<br><b>Freeland</b>                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 13e. STREET ADDRESS / ZIP CODE<br><b>21232 Millers Mill Rd., 21053</b>               |                              |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jerome Adam Ortt</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Johanna Scheuben</b>                                                                                    |  |                                                                                                            |  |                                                                                      |                              |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                          |  |                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-24-4981</b>                                                                               |  | 17. INFORMANT ADDRESS<br><b>Mary L. Ortt, same as 13e.</b>                                                 |  |                                                                                      |                              |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>                                                                                                                                                        |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                            |  |                                                                                      |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <div style="display: inline-block; vertical-align: middle; font-size: 3em; margin: 0 10px;">}</div> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic coronary vascular disease</b>                                     |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                            |  |                                                                                      |                              |                                                                                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                            |  |                                                                                      |                              |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Coronary artery bypass grafts, 1978</b>                                                                                                                                         |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                            |  |                                                                                      |                              |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                            |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                   |  |                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                                                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                             |  |                                                                                      |                              |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                             |  |                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                          |  |                                                                                      |                              |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |  |                                                                                                                                                      |  |                                                                                                                                                             |  |                                                                                                            |  |                                                                                      |                              |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Robert A. Palermo</i>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                      |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |                                                                                                            |  | 22c. DATE SIGNED<br><b>10/7/87</b>                                                   |                              |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Palermo, M.D.</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                                      |  | 22e. ADDRESS<br><b>6701 N. Charles St. Balto MD 21204</b>                                                                                                   |  |                                                                                                            |  |                                                                                      |                              |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                 |  |                                                                                                                                                      |  | 23b. DATE<br><b>10/10/87</b>                                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. Gardens</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium Balto. Md.</b>             |                              |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br><i>J. E. Lowell Lemmon</i><br>J. E. Lowell Lemmon, 10 W. Padonia Rd.                                                                                                                                                                                                                               |  |                                                                                                                                                      |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1987</b><br>25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i> |  |                                                                                      |                              |                                                                                                                            |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                               |                                                                     |                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                           |                                                                                                        | 2a. DATE OF DEATH                                                                                                                                        |                                                                               | 2b. HOUR                                                            |                                                                |
| DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                    |                                                                                                        | MONTH DAY YEAR                                                                                                                                           |                                                                               | MONTHS DAYS HOURS MIN.                                              |                                                                |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                |                                                                                                        | October 14, 1987                                                                                                                                         |                                                                               | 3:45p M                                                             |                                                                |
| 3. SEX                                                                                                                                                                                                                                                                                                                           | 4. RACE                                                                                                | 5. DATE OF BIRTH                                                                                                                                         | 6. AGE (IN YEARS (LAST BIRTHDAY))                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                                                |
| Male                                                                                                                                                                                                                                                                                                                             | White                                                                                                  | MONTH DAY YEAR                                                                                                                                           | 82 YRS                                                                        | Baltimore County MD                                                 |                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                        | 7b. CITIZEN OF WHAT COUNTRY?                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               |                                                                     |                                                                |
| Spain                                                                                                                                                                                                                                                                                                                            | USA                                                                                                    |                                                                                                                                                          |                                                                               |                                                                     |                                                                |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                             |                                                                     |                                                                |
| Rossville                                                                                                                                                                                                                                                                                                                        | Franklin Square Hospital                                                                               | Steel worker                                                                                                                                             | Beth. Steel                                                                   |                                                                     |                                                                |
| 13a. STATE                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 13b. COUNTY                                                                                                                                              | 13c. CITY OR TOWN                                                             | 13d. INSIDE CITY LIMITS?                                            | 13e. STREET ADDRESS / ZIP CODE                                 |
| Maryland                                                                                                                                                                                                                                                                                                                         | Baltimore                                                                                              | Edgemere                                                                                                                                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           | 6927 Riverdrive Road 21219                                          |                                                                |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                |                                                                                                        | 15. MOTHER'S MAIDEN NAME                                                                                                                                 |                                                                               |                                                                     |                                                                |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                |                                                                                                        | FIRST MIDDLE LAST                                                                                                                                        |                                                                               |                                                                     |                                                                |
| Simplicio Parada                                                                                                                                                                                                                                                                                                                 |                                                                                                        | Not Known                                                                                                                                                |                                                                               |                                                                     |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                |                                                                                                        | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                                                               | 17. INFORMANT ADDRESS                                               |                                                                |
| No                                                                                                                                                                                                                                                                                                                               |                                                                                                        | 213-07-2614                                                                                                                                              |                                                                               | Charles Lank 511 Newbury Ct. 21005                                  |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                          |                                                                               |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| Cardiopulmonary arrest.                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                          |                                                                               |                                                                     |                                                                |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                               |                                                                     |                                                                |
| DUE TO, OR AS A CONSEQUENCE OF (b) Extensive small cell cancer of lungs.                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                          |                                                                               |                                                                     |                                                                |
| DUE TO, OR AS A CONSEQUENCE OF (c) Acute respiratory failure.                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                          |                                                                               |                                                                     |                                                                |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                          |                                                                               |                                                                     |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                           |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                               | 20a. AUTOPSY?                                                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                               |                                                                                                        | 21b. TIME OF INJURY                                                                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                                                                     |                                                                |
|                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | HOUR A.M. MONTH DAY YEAR                                                                                                                                 |                                                                               |                                                                     |                                                                |
|                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | P.M. 19                                                                                                                                                  |                                                                               |                                                                     |                                                                |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                             |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION                                                                 |                                                                     |                                                                |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                          | CITY OR TOWN COUNTY STATE                                                     |                                                                     |                                                                |
| 22a. I certify that (X) (this hospital) attended the deceased from October 12, 1987, to October 14, 1987, that (X) (we) last saw the deceased alive on October 14, 1987, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |                                                                                                        |                                                                                                                                                          |                                                                               |                                                                     |                                                                |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                   |                                                                                                        | DEGREE                                                                                                                                                   |                                                                               | 22c. DATE SIGNED                                                    |                                                                |
| <i>[Signature]</i>                                                                                                                                                                                                                                                                                                               |                                                                                                        | MD                                                                                                                                                       |                                                                               | October 14, 1987                                                    |                                                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                            |                                                                                                        | 22e. ADDRESS                                                                                                                                             |                                                                               |                                                                     |                                                                |
| Julin Tang, M.D.                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 9000 Franklin Square Drive, Balto., 21237                                                                                                                |                                                                               |                                                                     |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                        |                                                                                                        | 23b. DATE                                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY                                            |                                                                     | 23d. LOCATION                                                  |
| Cremation                                                                                                                                                                                                                                                                                                                        |                                                                                                        | 10-15-87                                                                                                                                                 | Westview                                                                      |                                                                     | CITY OR TOWN COUNTY STATE                                      |
|                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                          |                                                                               |                                                                     | Baltimore Maryland                                             |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                        |                                                                                                        | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |                                                                               | 25b. REGISTRAR'S SIGNATURE                                          |                                                                |
| Duda-Ruck Funeral Home of Dundalk                                                                                                                                                                                                                                                                                                |                                                                                                        | OCT 19 1987                                                                                                                                              |                                                                               | <i>[Signature]</i>                                                  |                                                                |
| 7922 Wise Ave. Dundalk, MD 21222                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                          |                                                                               |                                                                     |                                                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

MEDICAL CERTIFICATION

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly including a list or table. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                   |                                                                                                                                                             |                                                                                           |                                                                                                 |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------|
| DECEASED NAME<br>(TYPE OR PRINT)<br>SUNG KYUNG PARK                                                                                                                                                                                                                                                                                                                      |                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 20 87                                                                                                             |                                                                                           | 2b. HOUR<br>12 <sup>10</sup> AM                                                                 |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>KOREAN                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 9 28                                                                                                                |                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59<br>YRS. MONTHS DAYS HOURS MIN.                            |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. KOREA                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br>South Korea                                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. COUNTY MD.                                       |                                              |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Stella Maris Hospice |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owner - Grocery Store |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                   | 13b. COUNTY<br>Baltimore                                                                                                                                    | 13c. CITY OR TOWN<br>Cockeysville                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sun Cu Park                                                                                                                                                                                                                                                                                                                    |                                                                                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sun Y. Park                                                                                                |                                                                                           |                                                                                                 |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                               |                                                                                                                                   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-72-5452                                                                                      |                                                                                           | 17. INFORMANT<br>ADDRESS<br>Mrs. Sung S. Park - same as #13e                                    |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal Cell Ca</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                    |                                                                                                                                   |                                                                                                                                                             |                                                                                           |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:                                                                                                                                                                                                                                       |                                                                                                                                   |                                                                                                                                                             |                                                                                           |                                                                                                 |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |                                                                                                                                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |                                                                                                                                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                           | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-18</u> , 19 <u>87</u> , to <u>10-20</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/20/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                   |                                                                                                                                                             |                                                                                           |                                                                                                 |                                              |
| 22b. SIGNATURE<br><u>Carla S. Alexander</u>                                                                                                                                                                                                                                                                                                                              |                                                                                                                                   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                           | 22c. DATE SIGNED                                                                                |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Carla S. Alexander, M.D.                                                                                                                                                                                                                                                                                                        |                                                                                                                                   | 22e. ADDRESS<br>Stella Maris Hospice<br>Dulaney Valley Rd. - Towson 21204                                                                                   |                                                                                           |                                                                                                 |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br>Burial                                                                                                                                                                                                                                                                                                                     |                                                                                                                                   | 23b. DATE<br>10-23-87                                                                                                                                       |                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley                                            |                                              |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium, Balto., Md.                                                                                                                                                                                                                                                                                                      |                                                                                                                                   | 23e. DATE REC'D. BY REGISTRAR<br>OCT 21 1987                                                                                                                |                                                                                           |                                                                                                 |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc., Towson, Md. 21204                                                                                                                                                                                                                                                                                        |                                                                                                                                   | 24b. REGISTRAR'S SIGNATURE<br><u>J. A. Davidson</u>                                                                                                         |                                                                                           |                                                                                                 |                                              |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked as item 18 above, injury, or other traumatic event, the medical examiner must be notified at once.

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

069668 OCT 26 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 28217

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                     |                                                                                 |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CARLIE F. PARRISH</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 16 87</b>                 |                                                                                                                                                             |                                                                     | 2b. HOUR<br>M<br><b>16</b>                                                      |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><b>Caucasian</b>                                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 4 02</b>                                                                                                         |                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS                                |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                                                                                               |                                                       | 7. IF UNDER 24 HRS<br>HOURS MIN.<br><b>0 0</b>           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. CAROLINA</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                    |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>             |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pimlico Manor Nursing Center</b> |                                                                        |                                                                                                                                                             |                                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>UNK.</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                             |                                                       |                                                          |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  | 13b. COUNTY<br><b>Baltimore</b>                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                               |                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                               | 13e. STREET ADDRESS<br><b>3101 BANCROFT RD. 21215</b> |                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNK.</b>           |                                                                                                                                                             |                                                                     |                                                                                 |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br><b>220-07-2505</b>                         |                                                                                                                                                             | 17. INFORMANT ADDRESS<br><b>FRANCES WEBSTER - daughter 472-2286</b> |                                                                                 |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Acc. Ent.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>green</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                     |                                                                                 |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                     |                                                                                 |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |                                                       |                                                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 29, 1987</u> to <u>Oct 16, 1987</u> , that (I) (we) lost saw the deceased alive on <u>Sept 29, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                     |                                                                                 |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
| 22b. SIGNATURE<br><u>Daniel J. Webb</u>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                     | DEGREE                                                                          |                                                                                                 | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                                       | 22c. DATE SIGNED<br><u>10/20/87</u>                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Daniel J. Webb</u>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                     | 22e. ADDRESS<br><u>10255 S. Baltimore Rd</u>                                    |                                                                                                 |                                                                                                                                               |                                                       |                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  | 23b. DATE<br><b>10-16-87</b>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY                                  |                                                                                 |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                    |                                                       |                                                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>State Anatomy Board</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |                                                                        |                                                                                                                                                             |                                                                     | ADDRESS<br><b>Balto., Md.</b>                                                   |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1987</b>                                                                                           |                                                       | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Tindon-Rodden</u> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28218

FOR  
1 - STATE  
REGISTRAR

|                                                                           |                 |                                                                    |  |                                                                                                                                                             |  |
|---------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>John R. Patton                        |                 | 2a. DATE OF DEATH MONTH DAY YEAR<br>10/14/87                       |  | 2b. HOUR<br>6:25 PM                                                                                                                                         |  |
| 3 SEX<br>male                                                             | 4 RACE<br>White | 5 DATE OF BIRTH MONTH DAY YEAR<br>8/17/23                          |  | 6 AGE IN YEARS (LAST BIRTHDAY)<br>64                                                                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                     |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Barto. County MD.                 |                 | 10. CITY OR TOWN OF DEATH<br>TOWSON                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Agent |                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Real Estate                   |  | 13a. STREET ADDRESS / ZIP CODE<br>1404 Limit Ave. 21239                                                                                                     |  |
| 13a. STATE<br>md                                                          |                 | 13b. COUNTY                                                        |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Samuel Patton                 |                 | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Elizabeth Riley |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes WW II                                                                           |  |
| 16b. SOCIAL SECURITY NO.<br>228126143                                     |                 | 17. INFORMANT<br>Virginia B. Patton                                |  | ADDRESS<br>Same                                                                                                                                             |  |

|                                                                                                                                                                |  |                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>IMMEDIATE</u> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CONGESTIVE HEART FAILURE</u>                                                                                          |  | <u>MONTHS</u>                                                    |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>                                                                          |  | <u>YEARS</u>                                                     |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  
CORONARY ARTERY DISEASE; ABDOMINAL AORTIC ANEURYSM REPAIR; COPD; ARF; GI

|                                                                                                                                                          |                                                                     |                                                                               |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                             | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                                                            |

22a. I certify that (this hospital) attended the deceased from 9-10, 19 87, to 10-14, 19 87, that (we) lost saw the deceased alive on 10-14, 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did not) view the body after death.

|                                                                    |                                                                        |                              |
|--------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------|
| 22b. SIGNATURE<br><u>Jorge C. Secada-Lovio, MD</u>                 | DEGREE<br>MD                                                           | 22c. DATE SIGNED<br>10-14-87 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jorge C. Secada-Lovio, MD | 22e. ADDRESS<br>57 JOSEPH HOSPITAL<br>7620 YORK ROAD, TOWSON, MD 21204 |                              |

|                                                               |                       |                                                           |                                                |
|---------------------------------------------------------------|-----------------------|-----------------------------------------------------------|------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial           | 23b. DATE<br>10/19/87 | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial   | 23d. LOCATION<br>Baltimore, Baltimore Co., Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home, Inc. |                       | ADDRESS<br>6500 York Rd.<br>Balto., Md. 21212             | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1987   |
|                                                               |                       | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Gordon-Lindell</u> |                                                |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 2 8 2 1 7

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |                                                                |                                                                                                                                                             |                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Elizabeth S. Peacock                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 10, 1987           |                                                                                                                                                             | 2b. HOUR<br>1:33 A <sub>M</sub>                 |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>White                                                                                                                                                                                                                                                                                                      |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 1, 1901                                                                                                          |                                                 |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.                                                                                                                                                                                                                                                                                                                                                                               |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                                                                                                                                                                                                    |                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Lawrenceville Geo.                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                   |                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                                                                                                       |                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3723 Crondall Lane                                                                                                                                                                                       |                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                               |                                                 |  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                                        |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                                     |                                                                | 13b. COUNTY<br>Balto.                                                                                                                                       |                                                 |  |
| 13c. CITY OR TOWN<br>Owings Mills                                                                                                                                                                                                                                                                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                  |                                                                | 13e. STREET ADDRESS / ZIP CODE<br>3723 Crondall Lane 21117                                                                                                  |                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Dr. M. A. Born                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl Hadaway |                                                                                                                                                             |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-32-6049                                                                                                                                                                                                                                                |                                                                | 17. INFORMANT<br>ADDRESS<br>Mr. George O. Tilton Balto. Md. 21207                                                                                           |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE CARDIORESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF - ASHD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>WBP</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1(a). |  |                                                                                                                                                                                                                                                                                                                       |                                                                |                                                                                                                                                             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |                                                                |                                                                                                                                                             |                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |                                                                |                                                                                                                                                             |                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |                                                                |                                                                                                                                                             |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                      |                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                 |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                            |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                              |                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                 |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                                                                                                                                           |  | 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                   |                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                 |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                        |  | 21g. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. |                                                                | 22b. SIGNATURE<br>DEGREE<br>R. RICCI MD                                                                                                                     |                                                 |  |
| 22c. DATE SIGNED<br>10/10/87                                                                                                                                                                                                                                                                                                                                                                                             |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. RICCI MD                                                                                                                                                                                                                                                                  |                                                                | 22e. ADDRESS<br>3725 BALTO. BLVD. FINKSBURG, MD 21048                                                                                                       |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial                                                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>10/12/87                                                                                                                                                                                                                                                                                                 |                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.                                                                                                      |                                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, Md.                                                                                                                                                                                                                                                                                                                                                            |  | 24. FUNERAL DIRECTOR<br>Eline Funeral Home Reisterstown, Md. 21136                                                                                                                                                                                                                                                    |                                                                | 25a. DATE REC'D. BY REGISTRAR<br>OCT 13 1987                                                                                                                |                                                 |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Gordon Linder                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                       |                                                                |                                                                                                                                                             |                                                 |  |

BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |  |                                                                                                                                             |  |                                                                        |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Gordon Hutchins H. Pearce, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                         |  |                                                                                                                                             |  |                                                                        |  |                                                                                                                                                             |  | 2a. DATE KNOWN OF DEATH<br><b>October 28, 1987</b>                                    |  | 2b. HOUR<br><b>1:00 PM</b>                                                          |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 3 1902</b>                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84 YRS.</b>                      |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                 |  | 7c. DATE PRONOUNCED DEAD<br><b>October 29, 1987</b>                                   |  | 7d. HOUR<br><b>1:00 PM</b>                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                  |  |                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                     |  |
| 11. CITY OR TOWN OF DEATH<br><b>Monkton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>16417 J. M. Pearce Rd.</b> |  |                                                                        |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Horse Trainer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Horses</b>                                  |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                         |  | 13b. CITY<br><b>Baltimore</b>                                                                                                               |  | 13c. CITY OR TOWN<br><b>Monkton</b>                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br><b>16417 J. M. Pearce Rd., 21111</b>                           |  |                                                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Myers Pearce</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                         |  |                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maude Hutchins</b> |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                         |  | (IF YES, GIVE WAR OR DATES)<br><b>-</b>                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>214-16-8250</b>                         |  | 17. INFORMANT<br>ADDRESS<br><b>21111 Robert M. Pearce, 16330 Markoe Rd.,</b>                                                                                |  |                                                                                       |  |                                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>RECORD + Leukemia</b> |  |                         |  |                                                                                                                                             |  |                                                                        |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                           |  |                                                                        |  |                                                                                                                                                             |  |                                                                                       |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                             |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                  |  |                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                                       |  |                                                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                 |  |                                                                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                       |  |                                                                                     |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                                          |  |                         |  |                                                                                                                                             |  |                                                                        |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                     |  |
| ACTUAL SIGNATURE<br><b>Chas. F. O'Donnell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                         |  | TITLE (SPECIFY)<br><b>Deputy Medical Examiner</b>                                                                                           |  |                                                                        |  | DATE SIGNED<br><b>10/29/87</b>                                                                                                                              |  |                                                                                       |  |                                                                                     |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Chas. F. O'Donnell, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                         |  | ADDRESS<br><b>7501 York Rd., 21204</b>                                                                                                      |  |                                                                        |  |                                                                                                                                                             |  |                                                                                       |  |                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                         |  | 23b. DATE<br><b>10/30/87</b>                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>        |  |                                                                                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Balto. Md.</b>           |  |                                                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Bryan W. Clary, 10 W. Padonia Rd., 21093</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  |                         |  |                                                                                                                                             |  | 25a. DATE OF D. BY REGISTRATION<br><b>NOV 2 1987</b>                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                                                                                 |  |                                                                                       |  |                                                                                     |  |

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NOV-3-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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|                                                                                                                                                                                                                                                                                                                  |  |                                                         |  |                                                                                      |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|------------------------------------|--|-----------------------------------------------------|--|----------------------------------------------------------------|--|----------------------------------------------|--|
| 069059 OCT 20 1987                                                                                                                                                                                                                                                                                               |  | FOR<br>STATE<br>REGISTRAR                               |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH |  | 87 7 2822                          |  | REG. NO.                                            |  |                                                                |  |                                              |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                              |  |                                                         |  | 2a. DATE OF DEATH                                                                    |  | MONTH                              |  | DAY                                                 |  | YEAR                                                           |  | 2b. HOUR                                     |  |
| Elizabeth Ann Pearson                                                                                                                                                                                                                                                                                            |  |                                                         |  | 10 -                                                                                 |  | 16 - 87                            |  | 7:29                                                |  | P                                                              |  |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                           |  | 4. RACE                                                 |  | 5. DATE OF BIRTH                                                                     |  | 6. AGE                             |  | 7. IF UNDER 1 YEAR                                  |  | 8. IF UNDER 24 HRS                                             |  |                                              |  |
| Female                                                                                                                                                                                                                                                                                                           |  | White                                                   |  | 03 31 - 1906                                                                         |  | 81                                 |  | YRS.                                                |  | MONTHS                                                         |  | DAYS                                         |  |
| 7a. BIRTHPLACE                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED                                                                           |  | NEVER MARRIED                      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                |  |                                                                |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                         |  | U.S.A.                                                  |  | WIDOWED                                                                              |  | DIVORCED                           |  | Baltimore County                                    |  | MD.                                                            |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION                                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                                     |  |                                                                |  |                                              |  |
| Towson                                                                                                                                                                                                                                                                                                           |  | St. Joseph Hospital                                     |  | Secretary                                                                            |  | Transportation                     |  |                                                     |  |                                                                |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                       |  |                                                         |  | 13b. CITY OR TOWN                                                                    |  | 13c. INSIDE CITY LIMITS?           |  | 13d. STREET ADDRESS / ZIP CODE                      |  |                                                                |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                         |  |                                                         |  | Baltimore                                                                            |  | YES                                |  | 2300 Dulaney Valley Rd 21204                        |  |                                                                |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                |  |                                                         |  | 15. MOTHER'S MAIDEN NAME                                                             |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| Henry J. Tiedebohl                                                                                                                                                                                                                                                                                               |  |                                                         |  | Anna Unknown                                                                         |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                                                     |  |                                                         |  | 16b. SOCIAL SECURITY NO.                                                             |  | 17. INFORMANT                      |  | ADDRESS                                             |  |                                                                |  |                                              |  |
| No                                                                                                                                                                                                                                                                                                               |  |                                                         |  | 219-10-9153                                                                          |  | Eleanor L. Goeller                 |  | 1510 Long Quarter Ct. Timonium, Md.                 |  | 21093                                                          |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                         |  |                                                         |  |                                                                                      |  |                                    |  |                                                     |  |                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                     |  |                                                         |  |                                                                                      |  |                                    |  |                                                     |  |                                                                |  | ONE YEAR                                     |  |
| IMMEDIATE CAUSE (a) ADENOCARCINOMA OF LEFT LUNG                                                                                                                                                                                                                                                                  |  |                                                         |  |                                                                                      |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                   |  |                                                         |  |                                                                                      |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                                   |  |                                                         |  |                                                                                      |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                   |  |                                                         |  |                                                                                      |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH                                                                                                                                                                                                                                                       |  |                                                         |  |                                                                                      |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |  |                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |  |                                    |  | 20a. AUTOPSY?                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                  |  |                                                         |  |                                                                                      |  |                                    |  | YES                                                 |  | YES                                                            |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING                                                                                                                                                                                                                                                                                     |  |                                                         |  | 21b. TIME OF INJURY                                                                  |  |                                    |  | 21c. HOW INJURY OCCURRED                            |  |                                                                |  |                                              |  |
| OR CONTRIBUTING CAUSE OF DEATH                                                                                                                                                                                                                                                                                   |  |                                                         |  | HOUR A.M. MONTH DAY YEAR                                                             |  |                                    |  | ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2 |  |                                                                |  |                                              |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                             |  |                                                         |  | P.M. 19                                                                              |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                             |  |                                                         |  | 21e. PLACE OF INJURY                                                                 |  |                                    |  | 21f. LOCATION                                       |  |                                                                |  |                                              |  |
| WHILE AT WORK                                                                                                                                                                                                                                                                                                    |  |                                                         |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]                                       |  |                                    |  | STREET                                              |  |                                                                |  |                                              |  |
| NOT WHILE AT WORK                                                                                                                                                                                                                                                                                                |  |                                                         |  |                                                                                      |  |                                    |  | CITY OR TOWN                                        |  |                                                                |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                  |  |                                                         |  |                                                                                      |  |                                    |  | COUNTY                                              |  |                                                                |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                  |  |                                                         |  |                                                                                      |  |                                    |  | STATE                                               |  |                                                                |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-30-87, 19, to 10-16-87, 19, that (we) last saw the deceased alive on 10-16-87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                         |  |                                                                                      |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                   |  |                                                         |  | DEGREE                                                                               |  |                                    |  | 22c. DATE SIGNED                                    |  |                                                                |  |                                              |  |
| Francis T. Khoo                                                                                                                                                                                                                                                                                                  |  |                                                         |  | MD                                                                                   |  |                                    |  | 10-16-87                                            |  |                                                                |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                            |  |                                                         |  | 22e. ADDRESS                                                                         |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| FRANCIS T. KHOO                                                                                                                                                                                                                                                                                                  |  |                                                         |  | St. Joseph Hospital                                                                  |  |                                    |  |                                                     |  |                                                                |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                                                                                                                                                                                  |  |                                                         |  | 23b. DATE                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION                                       |  |                                                                |  |                                              |  |
| Cremation                                                                                                                                                                                                                                                                                                        |  |                                                         |  | 10/19/1987                                                                           |  | Green Mount Crematory              |  | Baltimore                                           |  | Maryland                                                       |  |                                              |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                             |  |                                                         |  | 25a. DATE REC'D. BY REGISTRAR                                                        |  |                                    |  | 25b. REGISTRAR'S SIGNATURE                          |  |                                                                |  |                                              |  |
| Walter Brooks Bradley Inc. Balto., Md. 21222                                                                                                                                                                                                                                                                     |  |                                                         |  | OCT 19 1987                                                                          |  |                                    |  | Julia Gordon Rudek                                  |  |                                                                |  |                                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 472 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

Handwritten notes on lined paper, including the word "NOTION" and various illegible scribbles.



069417 OCT 23 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Thomas

Eric

Pedersen

2a. DATE KNOWN  
OF DEATH ESTI-  
MATED ☒ MONTH DAY YEAR

10 18 19 87

2b. HOUR  
M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

June 3, 1956

6. AGE (IN YEARS)

31

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c. DATE  
PRONOUNCED  
DEAD

10 18 19 87

2d. HOUR  
M

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

MD.

10. CITY OR TOWN OF DEATH

Freeland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

2451 E. Ruhl Road, Freeland, Md.

12a. USUAL OCCUPATION (TYPE OF WORK)

FOR MOST OF WORKING LIFE)

Quality Control

12b. KIND OF BUSINESS

OR INDUSTRY

Westinghouse

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Cockeysville

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

610 Knollcrest Pl., Apt. B, 21030

14. FATHER'S NAME

Thomas

MIDDLE

LAST

Pedersen, Jr.

15. MOTHER'S MAIDEN NAME

C.

MIDDLE

Joan

LAST

Paugh

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

218-68-5670

17. INFORMANT

ADDRESS Towson, Md. 21204

Thomas Pedersen, Jr., 18 Treeway Ct. 4D

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Shotgun wound of abdomen

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR 3:10 P.M. MONTH DAY YEAR  
10 18 19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Subject shot

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,

STREET, FACTORY, FARM, ETC.)

street/driveway

21f. LOCATION

Ruhl

2451 E. Ruhl Rd

CITY OR TOWN

COUNTY

Baltimore, MD

STATE

22. I certify that I took charge of the remains described above, held on

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☐Accident ☐Suicide ☐Homicide ☒Undetermined manner ☐

ACTUAL  
SIGNATURE

TITLE (SPECIFY)  
M.D. Assistant

MEDICAL EXAMINER

DATE  
SIGNED 10/19/87

EXAMINER'S NAME  
(TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

ADDRESS

111 Penn St.

Balto, MD.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

10-22-87

23c. NAME OF CEMETERY OR CREMATORY

Dulaney Valley

23d. LOCATION

Timonium,

Balto.,

Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

Ruck Towson Funeral Home, Inc., Towson, Md. 21204

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

OCT 21 1987

Galia Davidson-Rendell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 720. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

DHMH - 17  
(VR A15 ME (5))

090417 001300

WIDE WORLD

RECEIVED 10-10-62



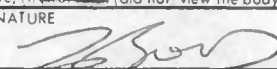
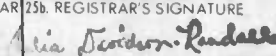
001300



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                  |                                                                                                                                                             |                                                                                 |                                                                                                                     |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>(Sister) Mary Elbert Peters</b>                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/22/87</b>                          |                                                                                                                     | 2b. HOUR<br>MIN<br><b>4:05P</b>                                                                                            |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br><b>White</b>                                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9/20/13</b>                                                                                                        | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>YRS MONTHS DAYS<br><b>74</b>               |                                                                                                                     | IF UNDER 1 YEAR<br>HOURS MIN<br><b>00 00</b>                                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.             |                                                                                                                     |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa Assumpta, 6401 N. Charles</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b> |                                                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>                                                                      |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                  |                                                                                                                                                             | 13b. COUNTY<br><b>Balto.</b>                                                    | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Peters</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Wetzelberger</b>       |                                                                                                                     |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>                                                                                                                                                                                                                                                                                                         |                                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br><b>215-68-4316</b>                                                                                                              | 17. INFORMANT<br>ADDRESS<br><b>S. Maria Goretti</b>                             |                                                                                                                     |                                                                                                                            |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain tumor</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b> |                                                                                                                                                  |                                                                                                                                                             |                                                                                 |                                                                                                                     |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                               |                                                                                                                                                  |                                                                                                                                                             |                                                                                 |                                                                                                                     |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                           |                                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                                                                                                     |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                       |                                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |                                                                                                                     |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>87</b> , to <b>October 22, 87</b> , that (I) (we) last saw the deceased alive on <b>Oct. 22, 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                                                |                                                                                                                                                  |                                                                                                                                                             |                                                                                 |                                                                                                                     |                                                                                                                            |
| 22b. SIGNATURE<br>                                                                                                                                                                                                                                                                                                              |                                                                                                                                                  | DEGREE                                                                                                                                                      |                                                                                 | 22c. DATE SIGNED                                                                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Lawrence Boas, M. D.</b>                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                  | 22e. ADDRESS<br><b>54 Scott Adam Rd., Cockeysville 21030</b>                                                                                                |                                                                                 |                                                                                                                     |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                         | 23b. DATE<br><b>10-26-87</b>                                                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Villa Maria Cemetery</b>                                                                                           |                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Arm Balto. Md.</b>                                            |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1987</b>                                                                                                         |                                                                                 | 25b. REGISTRAR'S SIGNATURE<br> |                                                                                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                               |                           | REG. NO. 28224                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Sarah G. Phillips</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                    |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10/6/87</b>                                              |  |                                                                               | 2b. HOUR<br><b>0835</b> M |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>Caucasian</b>                                                                                                                        |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9/4/94</b>                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS                                                |  | IF UNDER 1 YEAR MONTHS DAYS                                                   |                           | IF UNDER 24 HRS HOURS MIN.                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                      |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |                                                                               |                           |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Post Master</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Service</b>                     |                           |                                                                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                    |  | 13c. CITY OR TOWN<br><b>Randallstown</b>                                                                                                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>9134 Liberty Road 21133</b>              |                           |                                                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frank Griffith</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                    |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Verda Unknown</b>                              |  |                                                                               |                           |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>215-44-1086</b>                                                                                                     |  | 17. INFORMANT <b>Mr. William J. Phillips</b><br><b>5831 White Rock Road Sykesville Maryland 21784</b>                                                       |  |                                                                                                 |  |                                                                               |                           |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |                                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                               |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                               |                           |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |                                                                               |                           |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                  |  |                                                                               |                           |                                                                                                                            |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>9-27</b> , 19 <b>87</b> , to <b>10-6</b> , 19 <b>87</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>10-6</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did (did not) view the body after death.                                                      |  |                                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                               |                           |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Girgis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                    |  | DEGREE                                                                                                                                                      |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>10-6-87</b>                                            |                           |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rafat Girgis</b>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                    |  | 22e. ADDRESS<br><b>Baltimore County Md.</b>                                                                                                                 |  |                                                                                                 |  |                                                                               |                           |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                    |  | 23b. DATE<br><b>10/9/87</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laytonsville Cemetery</b>                              |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Laytonsville, Montgomery MD</b> |                           |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Loring Byers Funeral Directors, Inc.</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1987</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Swenson-Randall</b>                    |                           |                                                                                                                            |  |
| 2728 Liberty Road Randallstown Maryland 21133                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                               |                           |                                                                                                                            |  |



068353 OCT 14 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR2. DECEASED NAME  
(TYPE OR PRINT)FIRST  
Livia

MIDDLE

LAST

Pierorazio

3. DATE OF DEATH MONTH DAY YEAR

October 5, 1987

7b. HOUR

M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

April 15 1898

6. AGE (IN YEARS LAST BIRTHDAY)

89

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Italy

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

MD.

10. CITY OR TOWN OF DEATH

Dundalk

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

1953 Snyder Ave. 21222

12a. USUAL OCCUPATION

Own Home

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Dundalk

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

1953 Snyder Ave. 21222

14. FATHER'S NAME

FIRST  
Phillip

MIDDLE

LAST  
Di'Masso

15. MOTHER'S MAIDEN NAME

FIRST  
Jilda

MIDDLE

LAST  
Not Known

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)  
No

IF YES, GIVE WAR OR DATES

16b. SOCIAL SECURITY NO.

213-28-0213

17. INFORMANT

ADDRESS

Balto. MD 21222

Mrs. Mary Giorgilli 1953 Snyder Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic ovarian carcinoma

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

*SMilner*

DEGREE

*MD*ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

10/8/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. Sheldon Milner

22e. ADDRESS

404 Eastern Blvd. (21221)

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

10/9/87

23c. NAME OF CEMETERY OR CREMATORY

Sacred Heart of Jesus Dundalk Balto. Md

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

7922 Wise Ave. Balto. MD 21222

ADDRESS

Duda-Ruck Funeral Home of Dundalk, Inc.

25a. DATE REC'D. BY REGISTRAR

OCT 09 1987

25b. REGISTRAR'S SIGNATURE

*Lia Davidson-Randall*

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069914 OCT 27 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28220

|                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                    |                                                                                                                                                             |                                                                                       |                                                                                                                               |                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Raymond PINKETT</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>18</b> YEAR <b>87</b> HOUR <b>11:48pm</b> |                                                                                                                               |                                                    |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>Black</b>                                                                                                            | 5. DATE OF BIRTH<br>MONTH <b>01</b> DAY <b>22</b> YEAR <b>13</b>                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS                                      |                                                                                                                               | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore COUNTY MD.</b>                   |                                                                                                                               |                                                    |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disabled</b>   |                                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13a. COUNTY <b>MD</b>                                                                                                                                                                                                                            |                                                                                                                                    |                                                                                                                                                             | 13b. CITY OR TOWN<br><b>Baltimore</b>                                                 | 13c. STREET ADDRESS / ZIP CODE<br><b>1509 Laurens St 21217</b>                                                                |                                                    |
| 14. FATHER'S NAME<br>FIRST <b>NA</b> MIDDLE <b>NA</b> LAST <b>NA</b>                                                                                                                                                                                                                                                                                                  |                                                                                                                                    |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>NA</b> MIDDLE <b>NA</b> LAST <b>NA</b>           |                                                                                                                               |                                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b>                                                                                                                                                                                                                                                                                       |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br><b>212-14-1309</b>                                                                                                              | 17. INFORMANT<br>ADDRESS<br><b>Mrs. De Ann Bolden 2604 Keyworth Ave</b>               |                                                                                                                               |                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                |                                                                                                                                    |                                                                                                                                                             |                                                                                       |                                                                                                                               |                                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                                                    |                                                                                                                                    |                                                                                                                                                             |                                                                                       |                                                                                                                               |                                                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                     |                                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                           |                                                                                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                        |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)                                                                                         |                                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                 |                                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-18</b> , 19 <b>87</b> , to <b>10-18</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10-18</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                                                    |                                                                                                                                                             |                                                                                       |                                                                                                                               |                                                    |
| 22b. SIGNATURE<br><b>Camille M. Henry</b>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                    | DEGREE                                                                                                                                                      |                                                                                       | 22c. DATE SIGNED<br><b>10/15/87</b>                                                                                           |                                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Camille M. Henry</b>                                                                                                                                                                                                                                                                                                      |                                                                                                                                    | 22e. ADDRESS<br><b>Belvedere and Greenspring Baltimore</b>                                                                                                  |                                                                                       |                                                                                                                               |                                                    |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                         | 23b. DATE<br><b>10/26/87</b>                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet</b>                                                                                            |                                                                                       | 23d. LOCATION<br>CITY OR TOWN <b>Owings Mills</b> COUNTY <b>Md.</b> STATE                                                     |                                                    |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H West</b> ADDRESS <b>4300 Wabash Ave.</b>                                                                                                                                                                                                                                                                               |                                                                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 26 1987</b>                                                                                                         |                                                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>Julia D. Anderson</b>                                                                        |                                                    |

18750 = 17000



**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NAME  
EVANS CHARLES

1052 OCT 31 1961

| DATE     | TIME | LOCATION | WIND | TEMP | HUMID | SEA | WAVE | SWELL | WIND | TEMP | HUMID | SEA | WAVE | SWELL |
|----------|------|----------|------|------|-------|-----|------|-------|------|------|-------|-----|------|-------|
| 10/31/61 | 0800 | 10N 105E | 10   | 28   | 85    | S   | 2    | 10    | 10   | 28   | 85    | S   | 2    | 10    |
| 10/31/61 | 1200 | 10N 105E | 12   | 30   | 88    | S   | 2    | 10    | 12   | 30   | 88    | S   | 2    | 10    |
| 10/31/61 | 1600 | 10N 105E | 15   | 32   | 90    | S   | 2    | 10    | 15   | 32   | 90    | S   | 2    | 10    |
| 10/31/61 | 2000 | 10N 105E | 18   | 34   | 92    | S   | 2    | 10    | 18   | 34   | 92    | S   | 2    | 10    |
| 10/31/61 | 2400 | 10N 105E | 20   | 36   | 94    | S   | 2    | 10    | 20   | 36   | 94    | S   | 2    | 10    |



070459 NOV-28

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------|-----------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DOROTHY</b>                                                                                                                                                                                                                                                                                                               |  |  | FIRST MIDDLE LAST<br><b>PLUTA</b>                                                                                                                    |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10-26-87</b> |                                                                           |                                                                         |                                                                                                                            | 2b. HOUR<br><b>4 P.M.</b>                                         |                               |                                                     |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                             |  |  | 4. RACE<br><b>WHITE</b>                                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT. 1, 1900</b>                                                                                                  |                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>                              |                                                                         | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |                                                                   | IF UNDER 24 HRS<br>HOURS MIN. |                                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                        |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.       |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>                                                                                                                                                                                                                                                                                                                    |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>OLD COURT NURSING HOME</b>           |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                       |                                                                   |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b> |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                  |  |  | 13b. COUNTY<br><b>BALTO.</b>                                                                                                                         |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             |                                                     | 13d. STREET ADDRESS / ZIP CODE<br><b>7200 VALLEY COUNTRY CT. 21208</b>    |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISAAC LANDSMAN</b>                                                                                                                                                                                                                                                                                                     |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH GOLDSTEIN</b>                                                                              |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-18-8581</b>                                                                                                       |  | 17. INFORMANT <b>MR. HOWARD AMIRVIS</b><br><b>2318 CAVESDALE RD. OWINGS MILLS, MD 21117</b>                                                                 |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b>                                                                                                                                                                                                          |  |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 minutes</b> |                               |                                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____                                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                 |  |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                              |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |  |                                                                                                                                                             |                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                   |                               |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                           |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9-7</b> , 19 <b>87</b> , to <b>10-26</b> , 19 <b>87</b> , that (1) (he) last saw the deceased alive on <b>10-26</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| 22b. SIGNATURE<br><b>MB Seel</b>                                                                                                                                                                                                                                                                                                                                    |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         |                                                                                                                            | 22c. DATE SIGNED<br><b>10-26-87</b>                               |                               |                                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MB PERZIMAN</b>                                                                                                                                                                                                                                                                                                         |  |  | 22e. ADDRESS<br><b>5700 OZD COUNTRY RD</b>                                                                                                           |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                          |  |  | 23b. DATE<br><b>OCT. 27, 1987</b>                                                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMUNO</b>                                                                                                   |                                                     |                                                                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |                                                                                                                            |                                                                   |                               |                                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                                                                                                                                                                                                                                         |  |  |                                                                                                                                                      |  |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1987</b>    |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Julia Anderson-Randall</i>                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                                      |  |                                                                                                                                                             |                                                     |                                                                           |                                                                         |                                                                                                                            |                                                                   |                               |                                                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, there may be injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068858 001

FOR Item 3,23b Film G632 10-20-87  
STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
REGISTRAR per funeral home sbSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Margaret M. POSPISIL</b>                                                                                                                                                                                                                                                                                          |                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 14, 1987</b>                       |                                                                                                 | 2b. HOUR<br><b>1:21p M</b>                                                                                                 |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                           | 4 RACE<br><b>Cau.</b>                                                                                                                        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5/12/20</b>                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b>                                         | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                                   |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                 | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |                                                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                                                                                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                    |                                                                                                                                              | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                             | 13c. CITY OR TOWN<br><b>Rosedale</b>                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1255 Neighbors Avenue 21237</b>                                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Barker</b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br><b>210094907</b>                                                                                                                |                                                                                      | 17. INFORMANT<br>ADDRESS<br><b>William J. Pospisil 1255 Neighbors Av</b>                        |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b>                                                                                                                                                                                                                   |                                                                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                            |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <div style="display: inline-block; vertical-align: middle; font-size: 3em; margin: 0 10px;">}</div> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pulmonary hypertension<br/>Chronic obstructive pulmonary disease -</b> |                                                                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Metastatic multiple myeloma</b>                                                                                                                                                                                                       |                                                                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>October 13 87</b><br>P.M. 19                                                                          |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                   |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (this hospital) attended the deceased from <b>October 13 87</b> to <b>October 14 87</b> that (we) last saw the deceased alive on <b>October 14 87</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.                                                      |                                                                                                                                              |                                                                                                                                                             |                                                                                      |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br><b>Glise</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                              | DEGREE                                                                                                                                                      |                                                                                      | 22c. DATE SIGNED<br><b>10/14/87</b>                                                             |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jay Stern</b>                                                                                                                                                                                                                                                                                                                        |                                                                                                                                              | 22e. ADDRESS<br><b>9000 Franklin Square Dr. Balto., 21237</b>                                                                                               |                                                                                      |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                              | 23b. DATE<br><b>10-15-87</b>                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>                      |                                                                                                 | 23d. LOCATION<br><b>Baltimore, Maryland</b> STATE                                                                          |
| 24. FUNERAL DIRECTOR<br><b>1211 Chesaco Ave</b>                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 15 1987</b>                                                                                                         |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                     |                                                                                                                            |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                |                                                                        |                                                                                                                                                             |                                                      |                                                                                                                                                 |                                                                         |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>BEATRICE M. POST                                                                                                                                                                                                                                                                              |  |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 23 87                        |                                                                                                                                                             | 2b. HOUR<br>6:30 P.M.                                |                                                                                                                                                 |                                                                         |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>White                                                                                                               |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 9 25                                                                                                                |                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                                                                                      |                                                                         | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>STATEN ISL NY                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                                                    |                                                                         |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>DUNDALK                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERIDIAN HERITAGE |                                                                        |                                                                                                                                                             |                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor                                                                  |                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY<br>N.Y. Telephone Co.                                                                    |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                |                                                                        |                                                                                                                                                             |                                                      |                                                                                                                                                 |                                                                         |                                                                                                                            |  |
| 13b. COUNTY<br>BALTO                                                                                                                                                                                                                                                                                                                 |  | 13c. CITY OR TOWN<br>Timonium                                                                                                  |                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                                                      | 13e. STREET ADDRESS / ZIP CODE<br>6. Brooking Ct., Unit 302, 21093                                                                              |                                                                         |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sylvester Hogan                                                                                                                                                                                                                                                                            |  |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Flannagan       |                                                                                                                                                             |                                                      |                                                                                                                                                 |                                                                         |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                           |  |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>131-18-5130 |                                                                                                                                                             |                                                      | 17. INFORMANT<br>ADDRESS<br>Edwin P. Post - same as #13e                                                                                        |                                                                         |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Respiratory Arrest</i><br>DUE TO OR AS A CONSEQUENCE OF<br>(b) <i>Prob secondary to aspiration</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                                                |                                                                        |                                                                                                                                                             |                                                      |                                                                                                                                                 |                                                                         |                                                                                                                            |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Prob Stress ulcer Alzheimer Disease / recent Dental Surg</i>                                                                                                                                    |  |                                                                                                                                |                                                                        |                                                                                                                                                             |                                                      |                                                                                                                                                 |                                                                         |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                      | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                            |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                             |  |                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)                                                                 |                                                                         |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                       |  |                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                               |                                                                         |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |                                                                                                                                |                                                                        |                                                                                                                                                             |                                                      |                                                                                                                                                 |                                                                         |                                                                                                                            |  |
| 22b. SIGNATURE<br>Theo C. Patterson MD                                                                                                                                                                                                                                                                                               |  |                                                                                                                                | DEGREE<br>ATTENDING PHYSICIAN                                          |                                                                                                                                                             |                                                      | MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                                                         | 22c. DATE SIGNED<br>10/23/87                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THEO C. PATTERSON                                                                                                                                                                                                                                                                           |  |                                                                                                                                | 22e. ADDRESS<br>7232 Reemhull Rd                                       |                                                                                                                                                             |                                                      | 22f. ZIP CODE<br>21222                                                                                                                          |                                                                         |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                               |  |                                                                                                                                | 23b. DATE<br>10-27-87                                                  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley |                                                                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Balto., Md. |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc., Towson, Md. 21204                                                                                                                                                                                                                                                    |  |                                                                                                                                |                                                                        |                                                                                                                                                             |                                                      | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1987                                                                                                    |                                                                         | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                                                       |  |

MEDICAL CERTIFICATE

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (filled in) by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completed Pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                             |  |                                                                                                                                               |                       |                                                                                                                                                            |                                                             |                                                                                                                                           |                                                   |                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------|--|
| 1- REGISTRAR <i>Paul K. Murray</i>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                               |                       |                                                                                                                                                            | REG. NO.                                                    |                                                                                                                                           |                                                   |                                                                          |  |
| DECEASED NAME (TYPE OR PRINT)<br>Landone R. Pray                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |                       |                                                                                                                                                            | 2a DATE OF DEATH MONTH DAY YEAR<br>10 19 87                 |                                                                                                                                           |                                                   |                                                                          |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                    |  | 4 RACE<br>Caucasian                                                                                                                           |                       | 5 DATE OF BIRTH MONTH DAY YEAR<br>9-24-1912                                                                                                                |                                                             | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 yrs. YRS.                                                                                            |                                                   | 7b HOUR<br>11:50am                                                       |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Calif.                                                                                                                                                                                                                                                                               |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                            |                       | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                               |                                                   |                                                                          |  |
| 10 CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center |                       |                                                                                                                                                            |                                                             | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Liquor Clerk                                                           |                                                   | 12b KIND OF BUSINESS OR<br>Liquor Control Board                          |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.                                                                                                                                                                                                                               |  | 13b COUNTY<br>Balto.                                                                                                                          |                       | 13c CITY OR TOWN<br>Balto.                                                                                                                                 |                                                             | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |                                                   | 13e STREET ADDRESS / ZIP CODE<br>8716 Stockwell Road 21234               |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Hiram Pray                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               |                       |                                                                                                                                                            | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Clara Hoffman |                                                                                                                                           |                                                   |                                                                          |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>yes WWII                                                                                                                                                                                                                      |  |                                                                                                                                               |                       |                                                                                                                                                            | 16b SOCIAL SECURITY NO.<br>555-24-6276                      |                                                                                                                                           | 17 INFORMANT ADDRESS<br>Marilyn Pray same address |                                                                          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atenolol Overdose</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>End Stage mellanoma with metastasis (1981)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Dementia</u>                      |  |                                                                                                                                               |                       |                                                                                                                                                            |                                                             |                                                                                                                                           |                                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Chronic anemia and metabolic derangement</u>                                                                                                                                             |  |                                                                                                                                               |                       |                                                                                                                                                            |                                                             |                                                                                                                                           |                                                   |                                                                          |  |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               |                       | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                             |                                                                                                                                           |                                                   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                    |  |                                                                                                                                               |                       |                                                                                                                                                            |                                                             |                                                                                                                                           |                                                   |                                                                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                         |  |                                                                                                                                               |                       | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                             | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                                   |                                                                          |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                         |  |                                                                                                                                               |                       | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                             | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                   |                                                                          |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                               |                       |                                                                                                                                                            |                                                             |                                                                                                                                           |                                                   |                                                                          |  |
| 22b. SIGNATURE<br><i>Thomas R. Murray</i>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |                       |                                                                                                                                                            |                                                             | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                   | 22c. DATE SIGNED                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thomas R. Murray                                                                                                                                                                                                                                                                        |  |                                                                                                                                               |                       |                                                                                                                                                            |                                                             | 22e ADDRESS<br>G.B.M.C.                                                                                                                   |                                                   |                                                                          |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                            |  |                                                                                                                                               | 23b. DATE<br>10-22-87 |                                                                                                                                                            | 23c NAME OF CEMETERY OR CREMATORY<br>Garrison Forrest       |                                                                                                                                           |                                                   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Wings Mill, Md.             |  |
| 24 FUNERAL DIRECTOR<br>Schmunek Funeral Home, Inc.<br>9705 Belair Road, Balto., Md. 21236                                                                                                                                                                                                                                        |  |                                                                                                                                               |                       |                                                                                                                                                            |                                                             | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1987                                                                                              |                                                   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>              |  |

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*[Faint, mostly illegible text, possibly a ledger or account book entry. Some words like "BANK" and "BALANCE" are visible.]*

*[Handwritten signature or initials.]*

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                               |                                                                   |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                                                     |                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>David Jack Price</b>                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                               | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED<br><b>OCT 21 1987</b>      |                                                                                                                                                             |                                                                                                 | 2b. HOUR<br><b>5:32</b>                                                           |                                                                                     |                                                                   |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 13, 1926</b>                                                                                    | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>61</b> YRS.            | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                                                                    | IF UNDER 24 HRS.                                                                                | 2c. DATE PRONOUNCED DEAD<br><b>OCT 21 1987</b>                                    |                                                                                     |                                                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                           |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                   |                                                                                     |                                                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>                                                                                                                                                                                                                                                                                                                                                                                    |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |                                                                   |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b> |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Crown Cork &amp; Seal</b> |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                               | 13b. COUNTY<br><b>Baltimore</b>                                   | 13c. CITY OR TOWN<br><b>Essex</b>                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>620 S. Marlyn Ave. 21221</b>                            |                                                                                     |                                                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David E. Price</b>                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                               |                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Vera Kyle</b>                                                                                           |                                                                                                 |                                                                                   |                                                                                     |                                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                    |                         | 16b. SOCIAL SECURITY NO.<br><b>224 24 7386</b>                                                                                                |                                                                   | 17. INFORMANT<br><b>Rebecca Price</b>                                                                                                                       |                                                                                                 | ADDRESS<br><b>Same</b>                                                            |                                                                                     |                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTEROSCLEROTIC CARDIO-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>VASCULAR DISEASE</b><br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c)                                                          |                         |                                                                                                                                               |                                                                   |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                                                     |                                                                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                               |                                                                   |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                                                     |                                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |                                                                                                                                                             |                                                                                                 |                                                                                   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b> |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                                                                   |                                                                                     |                                                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                         |                         |                                                                                                                                               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                   |                                                                                     |                                                                   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                         |                                                                                                                                               |                                                                   |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                                                     |                                                                   |
| ACTUAL SIGNATURE<br><b>Paul F. Guerin</b>                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                               | TITLE (SPECIFY)<br>M.D. <b>DEPUTY</b>                             |                                                                                                                                                             |                                                                                                 | DATE SIGNED<br><b>10/21/87</b>                                                    |                                                                                     |                                                                   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>PAUL F. GUERIN</b>                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                                                               | ADDRESS<br><b>1201 KROGER RD BALTIMORE MD 21237</b>               |                                                                                                                                                             |                                                                                                 |                                                                                   |                                                                                     |                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                                                                                                               | 23b. DATE<br><b>10-24-87</b>                                      |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sherwood Mem. Park</b>                                 |                                                                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Salem, Virginia</b>                |                                                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Brundzinski Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                               | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1987</b>               |                                                                                                                                                             |                                                                                                 | 25b. REGISTRAR'S SIGN<br><b>J. H. Darden</b>                                      |                                                                                     |                                                                   |

DIVISION OF VITAL RECORDS, 101 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM WA-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 101 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

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DATE

1951

Jan 13, 1950

x

Washington County

USA

Virginia

STATION

Washington

Franklin Square Hospital

Washington 20001

x 250 W. Virginia Ave. 20001

Branch

Washington

Branch

Very late

David H. Price

Washington State

Jan 13, 1950

Branch

Branch

Washington State  
Branch

Branch

Branch

Branch

Branch

Branch

Branch

OCT 3 1951

Branch

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                         |                                                                        |                                                                                                                                                             |                                                                          |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                                                  |                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Alice PRIVETT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 25, 1987</b>         |                                                                                                                                                             | 2b. HOUR<br><b>12:55a<sub>M</sub></b>                                    |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                                                  |                                |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>White</b>                                                                 |                                                                        | 5. DATE OF BIRTH<br><b>Sept. 28, 1918</b>                                                                                                                   |                                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>                                                                                    |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                                                  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                              |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                             |                                                                                                 |                                                                                                                            |                                                                  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Franklin Sq. Hospital</b> |                                                                        |                                                                                                                                                             |                                                                          | 12a. USUAL OCCUPATION<br>(MOST OF WORKING LIFE)<br><b>Manager</b>                                                               |                                                                                                 | 12b. KIND OF BUSINESS OR<br><b>Apartments</b>                                                                              |                                                                  |                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                         | 13b. CITY<br><b>Baltimore</b>                                          |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Essex</b>                                        |                                                                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br><b>610 Delaware Ave. 21221</b> |                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clyde L. Robertson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Jones</b>   |                                                                                                                                                             |                                                                          | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>                                         |                                                                                                 |                                                                                                                            |                                                                  |                                |  |
| 16a. SOCIAL SECURITY NO.<br><b>235 26 1779</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                         | 17. INFORMANT<br><b>Clyde L. Ayers, Son</b>                            |                                                                                                                                                             |                                                                          | 18. ADDRESS<br><b>22001 Old Columbia Pike Silver Springs Md 20904</b>                                                           |                                                                                                 |                                                                                                                            |                                                                  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Lung Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>                                                                                                             |  |                                                                                         |                                                                        |                                                                                                                                                             |                                                                          |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                                                  |                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                   |                                                                                                 |                                                                                                                            |                                                                  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                               |                                                                                                 |                                                                                                                            |                                                                  |                                |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 23, 1987</b> to <b>October 25, 1987</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 25, 1987</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. |  |                                                                                         |                                                                        |                                                                                                                                                             |                                                                          |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                                                  |                                |  |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                         | DEGREE<br><b>M.D.</b>                                                  |                                                                                                                                                             |                                                                          | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br><b>10/25/87</b>                              |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeanne Liao, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                         | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>                 |                                                                                                                                                             |                                                                          |                                                                                                                                 |                                                                                                 |                                                                                                                            |                                                                  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                         | 23b. DATE<br><b>10/27/87</b>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Memorial Gardens</b> |                                                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>                         |                                                                                                                            |                                                                  |                                |  |
| 24. FUNERAL DIRECTOR<br><b>Brazdzinski Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1987</b>                    |                                                                                                                                                             |                                                                          | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                |                                                                                                 |                                                                                                                            |                                                                  |                                |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-7 2 8 2 3 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                              |         |                                                                                                           |                          |                                                                                                                                                             |                                                                     |                                                                  |                                 |                                   |                 |          |            |
|----------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------|-----------------------------------|-----------------|----------|------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                          |         | FIRST                                                                                                     | MIDDLE                   | LAST                                                                                                                                                        | 2a. DATE OF DEATH                                                   |                                                                  | MONTH                           | DAY                               | YEAR            | 2b. HOUR |            |
| MARY H. PUNTE                                                                                |         |                                                                                                           |                          |                                                                                                                                                             | 10/31/87                                                            |                                                                  |                                 |                                   |                 | 8 P.M.   |            |
| 3. SEX                                                                                       | 4. RACE |                                                                                                           | 5. DATE OF BIRTH         |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                                                                  | IF UNDER 1 YEAR                 |                                   | IF UNDER 24 HRS |          |            |
| F                                                                                            | Cauc.   |                                                                                                           | 5 7 08                   |                                                                                                                                                             | 79 YRS.                                                             |                                                                  | MONTHS                          |                                   | DAYS            |          | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                    |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |                                 |                                   |                 |          |            |
| Baltimore, Md.                                                                               |         | USA                                                                                                       |                          |                                                                                                                                                             |                                                                     | County (Balto.) MD.                                              |                                 |                                   |                 |          |            |
| 10. CITY OR TOWN OF DEATH                                                                    |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          |                                                                                                                                                             |                                                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                 | 12b. KIND OF BUSINESS OR INDUSTRY |                 |          |            |
| Towson                                                                                       |         | Stella Maris Hospice                                                                                      |                          |                                                                                                                                                             |                                                                     | Homemaker                                                        |                                 | Own Home                          |                 |          |            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |         |                                                                                                           | 13b. CITY OR TOWN        |                                                                                                                                                             | 13c. INSIDE CITY LIMITS?                                            |                                                                  | 13d. STREET ADDRESS / ZIP CODE  |                                   |                 |          |            |
| Md.                                                                                          |         |                                                                                                           | Balto.                   |                                                                                                                                                             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                  | 1612 Northbourne Rd Balto 21239 |                                   |                 |          |            |
| 14. FATHER'S NAME                                                                            |         |                                                                                                           | 15. MOTHER'S MAIDEN NAME |                                                                                                                                                             |                                                                     |                                                                  |                                 |                                   |                 |          |            |
| John Duke                                                                                    |         |                                                                                                           | Penelope Price           |                                                                                                                                                             |                                                                     |                                                                  |                                 |                                   |                 |          |            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                         |         |                                                                                                           | 16b. SOCIAL SECURITY NO. |                                                                                                                                                             | 17. INFORMANT ADDRESS                                               |                                                                  |                                 |                                   |                 |          |            |
| No                                                                                           |         |                                                                                                           | 217-22-1248              |                                                                                                                                                             | Stella Maris Hospice Dulaney Val. Rd 21204                          |                                                                  |                                 |                                   |                 |          |            |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cancer of Colon with metastasis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Arteriosclerotic Heart disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  |                                                                                                                                            |  |                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?                                                                                                                              |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  |                                                                                                                                            |  |                                                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  |                                                                                                                                            |  |                                                                   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>1/23/87</u> , 19 <u>87</u> , to <u>10/31</u> , 19 <u>87</u> , that (he/she) last<br>saw the deceased alive on <u>10/26</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (if we did (did not) view the body after death). |  |                                                                        |  |                                                                                                                                            |  |                                                                   |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                       |  | DEGREE                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  |                                                                                                                                            |  | 10/31/87                                                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS                                                           |  |                                                                                                                                            |  |                                                                   |  |
| E. Ipakchi, M.D.                                                                                                                                                                                                                                                                                                                                                     |  | Stella Maris Hospice, Towson Md 21204                                  |  |                                                                                                                                            |  |                                                                   |  |

|                                              |  |           |  |                                    |  |                                            |  |
|----------------------------------------------|--|-----------|--|------------------------------------|--|--------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) |  | 23b. DATE |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial                                       |  | 11/4/87   |  | Moreland Mem.                      |  | Balto. County, MD                          |  |
| 24. FUNERAL DIRECTOR<br>NAME                 |  |           |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE                 |  |
| H.W. Jenkins & Sons Co.                      |  |           |  | NOV 3 1987                         |  |                                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

72-101-60707



071285 NOV

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                           |  |                                                                        |  |                                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Helen Alveta Ryle</i>                                                      |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10/25/87</i>                 |  | 2b. HOUR<br><i>12:53 PM</i>                                                                                                                                 |  |
| 3. SEX<br><i>Female</i>                                                                                                                   |  | 4. RACE<br><i>Cauc</i>                                                 |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Jan. 30 1897</i>                                                                                                   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>90</i> YRS.                                                                                         |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                         |  | IF UNDER 24 HRS<br>HOURS MIN.                                                                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore</i> MD.                                                                              |  | 10. CITY OR TOWN OF DEATH<br><i>Towson</i>                             |  |                                                                                                                                                             |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holly Hill Manor N.H.</i> |  |                                                                        |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>                                                                        |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>                                                                                          |  |                                                                        |  | 13a. STREET ADDRESS / ZIP CODE<br><i>110N Tollgate Road 21014</i>                                                                                           |  |
| 13b. COUNTY<br><i>Harford</i>                                                                                                             |  | 13c. CITY OR TOWN<br><i>Bel Air</i>                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Samuel Orion</i>                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Alveta Watters</i> |  |                                                                                                                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>                                                         |  | 16b. SOCIAL SECURITY NO.<br><i>212-74-4419</i>                         |  | 17. INFORMANT<br>ADDRESS<br><i>Ruth A. Roesinger Fallston, Md.</i>                                                                                          |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                         |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>10 8 19 87</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)                                                             |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 8 19 87</i> to <i>present</i> , 19 <i>80</i> , that (I) (we) lost<br>saw the deceased alive on <i>Oct 8 19 87</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><i>Stephen LAIKEN</i>                                                                                                                                                                                                                                                                                                                 |  | DEGREE<br><i>MD</i>                                                    |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>10/29/87</i>                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Stephen LAIKEN</i>                                                                                                                                                                                                                                                                                          |  | 22e. ADDRESS<br><i>6805 YORK Rd. 21212</i>                             |  |                                                                                                                                            |  |                                                                                                                               |  |

|                                                                                    |  |                              |  |                                                              |  |                                                                             |  |
|------------------------------------------------------------------------------------|--|------------------------------|--|--------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                      |  | 23b. DATE<br><i>10/28/87</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>William Watters</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Cooptown, Harford, Md.</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>M. Gladden Kurtz Jarrettsville, Md.</i> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 02 1987</i>          |  | 25b. REGISTRAR'S SIGNATURE<br><i>one Davidson-Randall</i>                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit may be carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                               |  |                                                                                                                                    |  | REG. NO.                                                                                                                                                 |  |                                                                                                                         |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Theodore C. Quatman</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>10 19 87</b>                                                                                                         |  |                                                                                                                         |                                              |
| 3. SEX <b>male</b>                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE <b>Caucasian</b>                                                                                                           |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 14 1907</b>                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>                                                                               |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto.</b>                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.                                                           |                                              |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Maris Hospice</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PAINTING CONTRACTOR</b>                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                         |  | 13b. CITY OR TOWN <b>BALTO CITY</b>                                                                                                |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. STREET ADDRESS / ZIP CODE <b>1806 SHERWOOD AVE 21239</b>                                                           |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>THEODORE C. QUATMAN, SR.</b>                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SOPHIA HANDEL</b>                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO. <b>215-01-6244</b>                                                                                        |  | 17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>                                                                                                              |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Non Lymphocytic Leukemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                     |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>                                                                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                                                           |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/14/87</b> to <b>10/19/87</b> , that (I) <del>was</del> last saw the deceased alive on <b>10/19/87</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                         |                                              |
| 22b. SIGNATURE <b>Carla S. Alexander</b> DEGREE <b>M.D.</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>10/19/87</b>                                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carla S. Alexander, M.D.</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  | 22e. ADDRESS <b>Stella Maris Hospice Dulany Valley Rd. - Towson, MD 21204</b>                                                                            |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>                                                                                                                                                                                                                                                                                                      |  | 23b. DATE <b>10-22-1987</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>                                                                                               |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>                                                            |                                              |
| 24. FUNERAL DIRECTOR <b>EVANS CHAPEL OF MEMORIES</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1987</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>                                                                |                                              |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
**JOSEPH R. QUICK**

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 24  
**10 25 87 11 AM**

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
**November 21, 1931**

6. AGE (IN YEARS LAST BIRTHDAY)

55

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS HOURS MIN.  
YRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE

MD.

10. CITY OR TOWN OF DEATH

TOWSON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

STELLA MARIS HOSPICE

12a. USUAL OCCUPATION

Dispatcher - Security

12b. KIND OF BUSINESS OR INDUSTRY

Security

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

4600 Frankford Ave. Apt. B.  
21206

14. FATHER'S NAME

Edward

MIDDLE

Quick

LAST

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

Wunder

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

216-28-4555

17. INFORMANT

ADDRESS

Mechanicsburg, Pa.  
Mrs. Mary T. Boisvert 329 Indian Creek Dr.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

SMALL CELL LUNG CANCER - METASTATIC

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **10-23**, 19 **87**, to **10-25**, 19 **87**, that (I) (we) last saw the deceased alive on **10-25**, 19 **87**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Carla S. Alexander

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

10-25-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Carla S. Alexander, M.D.

22e. ADDRESS

Stella Maris Hospice  
Dulaney Valley Rd. - Towson, MD 21204

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Oct. 28, 1987

23c. NAME OF CEMETERY OR CREMATORY

Gdns. of Faith

23d. LOCATION

CITY OR TOWN

Baltimore

COUNTY

Maryland

STATE

24. FUNERAL DIRECTOR

NAME

Leonard J. Ruck Inc. Baltimore, Maryland

ADDRESS

25a. DATE OF DAY REGISTRATION

OCT 28 1987

25b. REGISTRAR'S SIGNATURE

Julia Deaton-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0701050

30% COTTON FIBER  
CHIEF KAM BOND



067903 OCT 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 7 2 8 2 3 8

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                              |                                                                                                                                                             |                                                                               |                                                                                                 |                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. DECEASED NAME (PRINT)<br>RUDOLPH C. RAWL                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH 10 DAY 04 YEAR 87                                                                                                                |                                                                               | 2b. HOUR<br>6:10 p.m.                                                                           |                                                       |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br>CAUC                                                                                                                              | 5. DATE OF BIRTH<br>MONTH 5 DAY 11 YEAR 11                                                                                                                  |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                                      |                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Lexington, S.C.                                                                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. COUNTY MD.                                        |                                                       |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC -6701 N. Charles St. 21204 |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Union local #109 |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                              | 13b. COUNTY<br>Baltimore                                                                                                                                    | 13c. CITY OR TOWN<br>Kingsville                                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                       |
| 14. FATHER'S NAME<br>FIRST George MIDDLE Allen LAST Rawl                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST Bessie MIDDLE Long LAST                                                                                                   |                                                                               |                                                                                                 |                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br>219-16-5537                                                                                                                     |                                                                               | 17. INFORMANT<br>ADDRESS 923 Waters Ave.<br>Mr. Wm. Barnhart, Fallston, Md. 21047               |                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Massive left cerebral &amp; brainstem infarct</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cerebral arteriosclerosis, severe</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                              |                                                                                                                                                             |                                                                               |                                                                                                 |                                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Arteriosclerotic coronary vascular heart disease</u>                                                                                                                                                                                                                                                |                                                                                                                                              |                                                                                                                                                             |                                                                               |                                                                                                 |                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                               | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                      |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/2, 19 87</u> , to <u>10/4, 19 87</u> , that (I) (we) last saw the deceased alive on <u>10/04, 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                   |                                                                                                                                              |                                                                                                                                                             |                                                                               |                                                                                                 |                                                       |
| 22b. SIGNATURE<br><i>Robert A. Palermo</i>                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                               | 22c. DATE SIGNED<br>10/05/87                                                                    |                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert A. Palermo, M.D.                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                              | 22e. ADDRESS<br>6701 N. Charles St. Balt. MD. 21204                                                                                                         |                                                                               |                                                                                                 |                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                              | 23b. DATE<br>10-8-1987                                                                                                                                      |                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Highview Mem. Gar. Fallston Harford Md.                   |                                                       |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                              | 23e. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                               | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |                                                       |
| 24. FUNERAL DIRECTOR<br>NAME E.F. Lassahn, ADDRESS 11750 Belair Rd. Kingsville, Md.                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                              | 25a. DATE REC'D BY REGISTRAR<br>OCT 07 1987                                                                                                                 |                                                                               | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                                      |                                                       |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

001803 OCT-88

Q-813 NOTED NO.02

QWED MKEFEI



001803



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                              |                                                                                                                                                             |                                                                                             |                                                                                                               |                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Jack Henry RAY</b>                                                                                                                                                                                                                                                                                                                     |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 27, 1987</b>                                                                                              |                                                                                             | 2b. HOUR<br><b>1:15a M</b>                                                                                    |                                                     |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br><b>White</b>                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 8, 1923</b>                                                                                                   |                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>                                                                  |                                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                           |                                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>                                                                                                                                                                                                                                                                                                                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Property Manager</b> |                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Housing</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                    |                                                                                                                                              | 13b. COUNTY<br><b>Harford</b>                                                                                                                               | 13c. CITY OR TOWN<br><b>Joppa</b>                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |                                                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Milton Houston Ray</b>                                                                                                                                                                                                                                                                                                              |                                                                                                                                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Vina Arnold</b>                                                                                         |                                                                                             |                                                                                                               |                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                               |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 414-32-3541</b>                                                                          |                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Baltimore, Md. 21222</b><br><b>Mrs. Jamie Leigh Cross, 5007 Broadmoor Road</b> |                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cancer of Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |                                                                                                                                              |                                                                                                                                                             |                                                                                             |                                                                                                               |                                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                               |                                                                                                                                              |                                                                                                                                                             |                                                                                             |                                                                                                               |                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                                     |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                       |                                                                                                                                              |                                                                                                                                                             |                                                                                             |                                                                                                               |                                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                |                                                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                     |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                             |                                                     |
| 22a. I certify that <b>Mr</b> (this hospital) attended the deceased from <b>September 29, 1987</b> to <b>October 27, 1987</b> , that <b>he</b> (we) lost saw the deceased alive on <b>October 27, 1987</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) (did) (did not) view the body after death. |                                                                                                                                              |                                                                                                                                                             |                                                                                             |                                                                                                               |                                                     |
| 22b. SIGNATURE<br><i>Mark [Signature]</i>                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                             | 22c. DATE SIGNED<br><b>10/27/87</b>                                                                           |                                                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NADCOM O'Connor</b>                                                                                                                                                                                                                                                                                                                  |                                                                                                                                              | 22e. ADDRESS<br><b>9000 Franklin Sq. Dr., 21237</b>                                                                                                         |                                                                                             |                                                                                                               |                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                       |                                                                                                                                              | 23b. DATE<br><b>Oct. 31, 1987</b>                                                                                                                           |                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Burchett Cemetery</b>                                                |                                                     |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Harrogate Clairborne Tenn.</b>                                                                                                                                                                                                                                                                                                  |                                                                                                                                              | 23e. DATE REC'D. BY REGISTRAR<br><b>OCT 30 1987</b>                                                                                                         |                                                                                             |                                                                                                               |                                                     |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Howard K. McComas III, Abingdon, Md. 21009</b>                                                                                                                                                                                                                                                                                                |                                                                                                                                              | 25. REGISTRAR'S SIGNATURE<br><i>Julia [Signature]</i>                                                                                                       |                                                                                             |                                                                                                               |                                                     |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0703-521

OCT 20 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                  |  | REG. NO.                                                                                                                                                    |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOSEPH R. RECKTENWALD                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCT. 20, 1987                                                                                                        |  |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                  |  | 4. RACE<br>White                                                                                                                                            |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4-5-13                                                                               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Balto., MD                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS                                                                                                                   |  | 7b. HOUR<br>2:38 P.M.                                                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                               |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Processor                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Johnston Lab.                                                                                                          |  |                                                                                                                            |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                  |  | 13b. COUNTY<br>Baltimore                                                                                                                                    |  | 13c. CITY OR TOWN                                                                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Mathias Recktenwald                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Krieg                                                                                                |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>067-07-3995                                                           |  | 17. INFORMANT<br>ADDRESS<br>Nettie S. Recktenwald, 2500 Linwood Rd. 21234                                                                                   |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ACUTE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>IMMEDIATE<br>DAYS<br>YEARS |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>DIABETES MELLITUS; HYPERTENSIVE CARDIOVASCULAR DISEASE; C.V.A.                                                                                                                                                                                          |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (this hospital) attended the deceased from 10-20, 19 87, to 10-20, 19 87, that (we) last saw the deceased alive on 10-20, 19 87, and that in (an) (our) apian death occurred on the date and hour and from the causes stated above. (we) (I) (did not) view the body after death.                                                                                       |  |                                                                                                                                  |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Jorge C. Secada-Lovio, MD                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>10-20-87                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JORGE C. SECADA-LOVIO, MD                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                  |  | 22e. ADDRESS<br>ST. JOSEPH HOSPITAL<br>7620 YORK RD. TOWSON, MD. 21204                                                                                      |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial Entombment                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br>10-24-87                                                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial                                                                                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD                                                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John C. Miller, Inc., 6415 Belair Rd. 21206                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                  |  | 25a. DATE RECD. BY REGISTRAR<br>OCT 24 1987                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br>J. C. Miller                                                                                 |  |



070946 NOV - 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                  |                                                 |                                                                                                                                                  |  |                                                                                                                               |                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>G. Calvin Reese                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 31 87 |                                                                                                                                                  |  | 2b. HOUR<br>11:30 PM                                                                                                          |                                                 |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>WHITE                                                                                                                 |                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 09 08                                                                                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS                                                                                     |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO. MD.                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           |                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CO. MD.                                                                        |                                                 |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |                                                 |                                                                                                                                                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>8318                                                      |                                                 |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br>BALTO                                                                                                             |                                                 | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                    |  | 13d. STREET ADDRESS / ZIP CODE<br>BERYL RD. 21234                                                                             |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE J. REESE                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                  |                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIE CATHERINE VOGEGES                                                                         |  |                                                                                                                               |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. 2 218-16-2202                                                    |                                                 | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS.                                                                                                      |  |                                                                                                                               |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |                                                                                                                                  |                                                 |                                                                                                                                                  |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                 |                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                       |                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)                                                                   |  |                                                                                                                               |                                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                           |                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |  |                                                                                                                               |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-19</u> , 19 <u>87</u> , to <u>10-31</u> , 19 <u>87</u> , that (I) (we) lost<br>saw the deceased alive on <u>10-31</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                         |  |                                                                                                                                  |                                                 |                                                                                                                                                  |  |                                                                                                                               |                                                 |
| 22b. SIGNATURE<br>Ethan Spiegler                                                                                                                                                                                                                                                                                                                                                                                                    |  | DEGREE<br>MD                                                                                                                     |                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>10-31-87                                                                                                  |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ETHAN SPIEGLER                                                                                                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS<br>ST. JOSEPH HOSPITAL                                                                                              |                                                 |                                                                                                                                                  |  |                                                                                                                               |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br>11-04-1987                                                                                                          |                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>DRUID RIDGE                                                                                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. CO. MARYLAND                                                             |                                                 |
| 24. FUNERAL DIRECTOR<br>EVANS CHAPEL OF MEMORIES                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  |                                                 | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1987                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                     |                                                 |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                                                          |                                                         |                                                                                              |  |                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                           |  |                                                                                                                                 |  |                                                                                                                                                          |                                                         |                                                                                              |  |                                                                                                                         |  |
| REG. NO. 87 28 244                                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |  |                                                                                                                                                          |                                                         |                                                                                              |  |                                                                                                                         |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paula Clotel REGATO                                                                                                                                                                                                                                           |  |                                                                                                                                 |  |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR October 6, 1987        |                                                                                              |  | 2b. HOUR 9:20p M                                                                                                        |  |
| 3. SEX F                                                                                                                                                                                                                                                                                                         |  | 4. RACE W                                                                                                                       |  | 5. DATE OF BIRTH MONTH DAY YEAR 6 3 04                                                                                                                   |                                                         | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.                                                      |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CUBA                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY? CUBA                                                                                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                         | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.                                    |  |                                                                                                                         |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL |  |                                                                                                                                                          |                                                         | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEVER WORKED                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |  |
| 13a. STATE MD.                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY BALTO.                                                                                                              |  | 13c. CITY OR TOWN BALTIMORE                                                                                                                              |                                                         | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE 21221 1607 E. RICKENBACKER RD.                                                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANCISCO VALLES                                                                                                                                                                                                                                                             |  |                                                                                                                                 |  |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANA MARTINEZ |                                                                                              |  |                                                                                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO. 212-28-3500                                                                                            |  | 17. INFORMANT ADDRESS DAISEY DOUGHNEY - daughter 7325 STRATTON WAY - 282-0347                                                                            |                                                         |                                                                                              |  |                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                        |  |                                                                                                                                 |  |                                                                                                                                                          |                                                         |                                                                                              |  |                                                                                                                         |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest.                                                                                                                                                                                                                                         |  |                                                                                                                                 |  |                                                                                                                                                          |                                                         |                                                                                              |  |                                                                                                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Massive anterolateral myocardial infarction.                                                                                                                                                                                                                                  |  |                                                                                                                                 |  |                                                                                                                                                          |                                                         |                                                                                              |  |                                                                                                                         |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                               |  |                                                                                                                                 |  |                                                                                                                                                          |                                                         |                                                                                              |  |                                                                                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.                                                                                                                                                                                |  |                                                                                                                                 |  |                                                                                                                                                          |                                                         |                                                                                              |  |                                                                                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                |  |                                                                                                                                                          |                                                         | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                           |                                                         |                                                                                              |  |                                                                                                                         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                         | October 6, 87 October 6, 87                                                                  |  |                                                                                                                         |  |
| 22a. I certify that (this hospital) attended the deceased from October 6, 87, to October 6, 87, that (we) last saw the deceased alive on October 6, 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                 |  |                                                                                                                                                          |                                                         |                                                                                              |  |                                                                                                                         |  |
| 22b. SIGNATURE Mohamed Alabrash                                                                                                                                                                                                                                                                                  |  | DEGREE M.D.                                                                                                                     |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |                                                         | 22c. DATE SIGNED 10/6/87                                                                     |  |                                                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mohamad Alabrash, M.D.                                                                                                                                                                                                                                                     |  |                                                                                                                                 |  | 22e. ADDRESS 9000 Franklin Square Drive, Balto., 21237                                                                                                   |                                                         |                                                                                              |  |                                                                                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal                                                                                                                                                                                                                                                                |  | 23b. DATE 10-7-87                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                         | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                         |  |
| 24. FUNERAL DIRECTOR NAME State Anatomy Board                                                                                                                                                                                                                                                                    |  |                                                                                                                                 |  | ADDRESS Balto., Md.                                                                                                                                      |                                                         | 25a. DATE REC'D. BY REGISTRAR OCT 09 1987                                                    |  | 25b. REGISTRAR'S SIGNATURE John Davidson                                                                                |  |

088288 CCI 14 03



69455 OCT 23

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                      |                                                                                                                                                             |                                                                                                            |                                                                                      |                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Leona M. K. Rein                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 19, 1987                                                    |                                                                                      | 2b. HOUR<br>Noon <sup>M</sup>                                                                                                         |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br>White                                                                                                                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4-3-1917                                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS                                                                  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                   |                                                                                                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                               |                                                                                      |                                                                                                                                       |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Saint Joseph's Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerical                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired                                         |                                                                                                                                       |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                      |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                                                                   | 13c. CITY OR TOWN<br>Baltimore                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Adam P. Quick                                                                                                                                                                                                                                                                                                                             |                                                                                                                                      |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lena Kautsch 21234                                        |                                                                                      |                                                                                                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                                                                              |                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br>214-01-8136                                                                                                                     | 17. INFORMANT<br>ADDRESS<br>GEOrgE T. Rein Jr.-1753 Joan AVE.-21234                                        |                                                                                      |                                                                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                      |                                                                                                                                                             |                                                                                                            |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u>                                                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                              |                                                                                                                                      |                                                                                                                                                             |                                                                                                            |                                                                                      |                                                                                                                                       |
| 19a. DATE OF OPERATION<br>—                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—                                                                                                       |                                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                             |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. — 19                                                                                                | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>—                     |                                                                                      |                                                                                                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                        |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>— — — — —                                             |                                                                                      |                                                                                                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-29, 1975</u> , to <u>10-19, 1987</u> , that (I) (we) last saw the deceased alive on <u>10-19-87</u> , 19 —, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                        |                                                                                                                                      |                                                                                                                                                             |                                                                                                            |                                                                                      |                                                                                                                                       |
| 22b. SIGNATURE<br><u>Frank G. Kuehn MD</u>                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                      | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                                            | 22c. DATE SIGNED<br><u>10/20/87</u>                                                  |                                                                                                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>FRANK G. KUEHN</u>                                                                                                                                                                                                                                                                                                                      |                                                                                                                                      | 22e. ADDRESS<br><u>7600 OSLER DRIVE TOWSON 4</u>                                                                                                            |                                                                                                            |                                                                                      |                                                                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                              | 23b. DATE<br>10-22-87                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery                                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                                          |                                                                                      |                                                                                                                                       |
| 24. FUNERAL DIRECTOR<br>NAME<br>John C. Miller, Inc.-6415 Belair Rd.-21206                                                                                                                                                                                                                                                                                                          |                                                                                                                                      |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Radner</u><br>OCT 22 1987 |                                                                                      |                                                                                                                                       |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                             |  | REG. NO. 8 7 2 8 2 4 1                                                                                 |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 1. DECEASED NAME (PE OR PRINT)                                                                                                                                                                                                                                                                     |  | FIRST                                                                                                  |  | MIDDLE                                                                                                                                                   |  | LAST                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                        |  | 2b. HOUR P M                                 |  |
| William Wesley Renner, Jr.                                                                                                                                                                                                                                                                         |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  | October 3, 1987                                                                                                         |  | 4:30 P M                                     |  |
| 3. SEX                                                                                                                                                                                                                                                                                             |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.                                                         |  | 7. IF UNDER 1 YEAR MONTHS DAYS                                                                                          |  | 7b. IF UNDER 24 HRS. HOURS MIN.              |  |
| Male                                                                                                                                                                                                                                                                                               |  | White                                                                                                  |  | 12/4/1916                                                                                                                                                |  | 70                                                                                           |  |                                                                                                                         |  |                                              |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                         |  |                                                                                                                         |  |                                              |  |
| Md.                                                                                                                                                                                                                                                                                                |  | USA                                                                                                    |  |                                                                                                                                                          |  | Baltimore County MD.                                                                         |  |                                                                                                                         |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| Lansdowne                                                                                                                                                                                                                                                                                          |  | 120 Second Ave., 21227                                                                                 |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                                                                                                                                                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                      |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| Ret. Balto. City Fireman                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE                                                                                          |  |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                           |  | Baltimore                                                                                              |  | Lansdowne                                                                                                                                                |  |                                                                                              |  | 120 Second Ave., 21227                                                                                                  |  |                                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                               |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| William Wesley Renner, Sr.                                                                                                                                                                                                                                                                         |  |                                                                                                        |  | Carrie Hall                                                                                                                                              |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                                                   |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                                                      |  |                                                                                                                         |  |                                              |  |
| Yes                                                                                                                                                                                                                                                                                                |  | WW 2                                                                                                   |  | 212-07-8828                                                                                                                                              |  | Rose E. Renner Same as #13                                                                   |  |                                                                                                                         |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                              |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u>                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  | 15 months                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Shelton Metastasis</u>                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  | 12 weeks                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |                                                                                                                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
|                                                                                                                                                                                                                                                                                                    |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
|                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-1-1986 to 10-3-1987, that (I) (we) last saw the deceased alive on 10-3-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                     |  | DEGREE                                                                                                 |  |                                                                                                                                                          |  | 22c. DATE SIGNED                                                                             |  |                                                                                                                         |  |                                              |  |
|                                                                                                                                                                                                                                                                                                    |  |                                                                                                        |  |                                                                                                                                                          |  | 10-5-87                                                                                      |  |                                                                                                                         |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                              |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| DR. B.S. KARPEAS JR.                                                                                                                                                                                                                                                                               |  | 1014 W. READ ST. RM 107 Balto. Md. 21201                                                               |  |                                                                                                                                                          |  |                                                                                              |  |                                                                                                                         |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                      |  |                                                                                                                         |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                             |  | 10/7/87                                                                                                |  | Glen Haven Mem Pk.                                                                                                                                       |  | Glen Burnie, A.A. Co., Md                                                                    |  |                                                                                                                         |  |                                              |  |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                          |  | 24b. ADDRESS                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                                                   |  |                                                                                                                         |  |                                              |  |
| McCully Funeral Homes Balto.                                                                                                                                                                                                                                                                       |  | 237 E. Patapsco Ave. Md. 21225                                                                         |  | OCT 6 1987                                                                                                                                               |  |                                                                                              |  |                                                                                                                         |  |                                              |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |  |                                                                                                                                                              |                                     |                                                                                                              |  |                                                                                                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       |  |                                                                                                                                                              | REG. NO.                            |                                                                                                              |  |                                                                                                                           |  |
| 2. DECEASED NAME (TYPE OR PRINT)<br><b>Joseph A. Rice</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |  |                                                                                                                                                              | 3. DATE OF DEATH<br><b>10/02/87</b> |                                                                                                              |  | 4. HOUR<br><b>M</b>                                                                                                       |  |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                          |  | 6. RACE<br><b>Caucasian</b>                                                                                                           |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/11/16</b>                                                                                                         |                                     | 8. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS                                                             |  | 9. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>71</b>                                                                            |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                   |  | 11. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                         |  | 12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 13. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                         |  |                                                                                                                           |  |
| 14. CITY OR TOWN OF DEATH<br><b>Pikesville</b>                                                                                                                                                                                                                                                                                                                 |  | 15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>20 Randall Avenue</b> |  |                                                                                                                                                              |                                     | 16. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Lt. Col.</b>                   |  | 17. KIND OF BUSINESS OR INDUSTRY<br><b>United States Army</b>                                                             |  |
| 18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>18a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                   |  | 18b. COUNTY<br><b>Baltimore</b>                                                                                                       |  | 18c. CITY OR TOWN<br><b>Pikesville</b>                                                                                                                       |                                     | 18d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  | 18e. STREET ADDRESS / ZIP CODE<br><b>20 Randall Avenue 21208</b>                                                          |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Henry Rice</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |  | 20. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Vaughn</b>                                                                                         |                                     |                                                                                                              |  |                                                                                                                           |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>yes WW 2 &amp; Korea</b>                                                                                                                                                                                                                                 |  |                                                                                                                                       |  | 22. SOCIAL SECURITY NO.<br><b>224-09-0424 A</b>                                                                                                              |                                     | 23. INFORMANT<br><b>Mrs. Constance Rice</b><br>ADDRESS<br><b>20 Randall Avenue Pikesville Maryland 21208</b> |  |                                                                                                                           |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic colon carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.           |  |                                                                                                                                       |  |                                                                                                                                                              |                                     |                                                                                                              |  | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>                                                        |  |
| 26. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>                                                                                                                                                                                                                 |  |                                                                                                                                       |  |                                                                                                                                                              |                                     |                                                                                                              |  |                                                                                                                           |  |
| 27. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |  | 28. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |                                                                                                                                                              |                                     | 29. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 30. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 31. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                        |  | 32. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                      |  | 33. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                |                                     |                                                                                                              |  |                                                                                                                           |  |
| 34. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                       |  | 35. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |  | 36. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                             |                                     |                                                                                                              |  |                                                                                                                           |  |
| 37. I certify that (I) (this hospital) attended the deceased from <b>10/1/87</b> 19 <b>87</b> , to <b>10/2</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>9/21</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                       |  |                                                                                                                                                              |                                     |                                                                                                              |  |                                                                                                                           |  |
| 38. SIGNATURE<br><b>Marc D. Sokolow</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |  | 39. DEGREE<br><b>MD</b>                                                                                                                                      |                                     |                                                                                                              |  | 40. DATE SIGNED<br><b>10/5/87</b>                                                                                         |  |
| 41. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marc D. Sokolow M.D.</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |  | 42. ADDRESS<br><b>333 St. Paul Place Balto 21202</b>                                                                                                         |                                     |                                                                                                              |  |                                                                                                                           |  |
| 43. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                      |  | 44. DATE<br><b>10/05/87</b>                                                                                                           |  | 45. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest V.A. Cem.</b>                                                                                        |                                     | 46. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore MD</b>                                   |  | 47. DATE REC'D. BY REGISTRAR<br><b>OCT 06 1987</b>                                                                        |  |
| 48. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc</b><br><b>8728 Liberty Road Randallstown Maryland 21133</b>                                                                                                                                                                                                                             |  |                                                                                                                                       |  | 49. REGISTRAR'S SIGNATURE<br><b>Frederick Randall</b>                                                                                                        |                                     | 50. REGISTRAR'S SIGNATURE                                                                                    |  |                                                                                                                           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4, with the carbon papers, pages 1 and 2, should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



068570 OCT 14 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28246

|                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                                                 |                                                                                                        |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Jerome A. Richardson                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                 | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>10/ 3/ 1987 |                                                                                                                                                             |                                                                                                             | 2b. HOUR<br>7:50 a.m.                                                                           |                                                                                     |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 16, 1939                                                                            | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN<br>48 YRS.                                    | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN                                                                                                                     | IF UNDER 24 HRS.<br>HOURS MIN                                                                               | 2c. DATE PRONOUNCED DEAD<br>10/ 3/ 1987                                                         |                                                                                     |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash., D.C.                                                                                                                                                                                                                                                                                                                                                                                 |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                             |                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |                                                                                     |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>695 at 11A cutoff |                                                                                                        |                                                                                                                                                             |                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>none                           |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>Washington, D.C.                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 13b. COUNTY                                                                                                                     |                                                                                                        | 13c. CITY OR TOWN                                                                                                                                           |                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                     |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Richardson                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                 |                                                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Johnson                                                                                              |                                                                                                             |                                                                                                 |                                                                                     |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                                              |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>579 50 7384                                                          |                                                                                                        | 17. INFORMANT<br>ADDRESS<br>Helen Ferguson-mother-236 Gallatin St., N.W.                                                                                    |                                                                                                             |                                                                                                 |                                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). Multiple Injuries<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b).<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c).                                                                                                  |                  |                                                                                                                                 |                                                                                                        |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                      |                  |                                                                                                                                 |                                                                                                        |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                      |                                                                                                                                                             |                                                                                                             |                                                                                                 | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 10/ 3/ 1987                                    |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>pedestrian struck by autos |                                                                                                 |                                                                                     |                                              |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                                                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>roadway                                 |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>695 at 11A cutoff, Balto. County, Md.                  |                                                                                                 |                                                                                     |                                              |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |                                                                                                                                 |                                                                                                        |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                              |
| ACTUAL SIGNATURE<br>Charles P. Kokes                                                                                                                                                                                                                                                                                                                                                                                                     |                  |                                                                                                                                 | TITLE (SPECIFY)<br>M.D. Assistant                                                                      |                                                                                                                                                             |                                                                                                             | DATE SIGNED<br>10/3/87                                                                          |                                                                                     |                                              |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Charles P. Kokes, M.D.                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                                                 | ADDRESS<br>111 Penn St., Balto., Md. 21201                                                             |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                   |                  |                                                                                                                                 | 23b. DATE<br>Oct. 10, 1987                                                                             |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial                                                      |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Md.                         |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br>Stewart                                                                                                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                                                 | ADDRESS<br>Home-4001 Benning Road, N.E.                                                                |                                                                                                                                                             |                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>OCT 09 1987                                                    |                                                                                     |                                              |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                 |                                                                                                        |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                              |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT (PAGE 1) AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

000210 Oct 18 61



70453 NOV-28

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                         |                                                                                                                                                             |                                                                                                       |                                                                                                 |                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DONALD A. RICKS                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 28, 1987                                               |                                                                                                 | 2b. HOUR<br>M                                                                     |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br>White                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 28, 1906                                                                                                         |                                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS                                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD                                    |                                                                                   |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1447 Putty Hill Ave. 21204 |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Assist. Superintendent City Parks |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                 |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 13b. COUNTY<br>Baltimore                                                                                                                                    | 13c. CITY OR TOWN<br>Towson                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John A. Ricks                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lottie Cornell                                                                                             |                                                                                                       |                                                                                                 |                                                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-01-7742                                                                                      |                                                                                                       | 17. INFORMANT<br>ADDRESS<br>Alice E. Ricks 21204<br>1447 Putty Hill Ave.                        |                                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                                                                                                                         |                                                                                                                                                             |                                                                                                       |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hours</u><br><u>20 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                                                                     |                                                                                                                                         |                                                                                                                                                             |                                                                                                       |                                                                                                 |                                                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                                                                                                                                                             |                                                                                                       |                                                                                                 |                                                                                   |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |                                                                                                       |                                                                                                 |                                                                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                       | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |                                                                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)                                                                                        |                                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/23/87</u> , 19 <u>80</u> , to <u>10/28/87</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/23/87</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                             |                                                                                                                                         |                                                                                                                                                             |                                                                                                       |                                                                                                 |                                                                                   |
| 22b. SIGNATURE<br><u>Paul J. Edgar, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                         | DEGREE                                                                                                                                                      |                                                                                                       | 22c. DATE SIGNED<br><u>10/29/87</u>                                                             |                                                                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul J. Edgar, M.D.                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                         | 22e. ADDRESS<br>660 Kenilworth Ave. Towson, MD                                                                                                              |                                                                                                       |                                                                                                 |                                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         | 23b. DATE<br>OCT. 31, '87                                                                                                                                   |                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>LORRAINE PARK                                             |                                                                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CO., MARYLAND                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                         | 23e. DATE REC'D. BY REGISTRAR<br>OCT 30 1987                                                                                                                |                                                                                                       |                                                                                                 |                                                                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>WILLIAM E. JOHNSON                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 25. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                    |                                                                                                       |                                                                                                 |                                                                                   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician must be notified at once.

BP

CHIEF  
2085  
ADJUTANT  
GENERAL  
OFFICE

2085  
ADJUTANT  
GENERAL  
OFFICE

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                    |                                                                   |                                                                                                                                                             |                                                                                        |                                                                                                 |                                                           |                                                                                                                            |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME (PRINT)<br><b>ETHEL RISBERG</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>22</b> YEAR <b>87</b> |                                                                                                                                                             |                                                                                        | 2b. HOUR<br><b>2:40</b> M                                                                       |                                                           |                                                                                                                            |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>White</b>                                                                                                                            |                                                                   | 5. DATE OF BIRTH<br>MONTH <b>03</b> DAY <b>14</b> YEAR <b>07</b>                                                                                            |                                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS                                                |                                                           | 7. IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b>                                                                      |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                      |                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |                                                           |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County Gen. Hospital</b> |                                                                   |                                                                                                                                                             |                                                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |                                                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>                                                                       |                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                               |  |                                                                                                                                                    |                                                                   |                                                                                                                                                             |                                                                                        |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>Carroll</b>                                                                                                                      |                                                                   | 13c. CITY OR TOWN<br><b>Sykesville</b>                                                                                                                      |                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                           | 13e. STREET ADDRESS<br><b>558 Obrecht Road 21784</b>                                                                       |                                              |
| 14. FATHER'S NAME<br>FIRST <b>Henry</b> MIDDLE <b>Walker</b> LAST <b>Walker</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                    |                                                                   |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ida</b> MIDDLE <b>Thorsen</b> LAST <b>Thorsen</b> |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-----</b>                                                                            |                                                                   | 17. INFORMANT<br><b>Don Haas</b> ADDRESS<br><b>558 Obrecht Road Sykesville, Maryland 21784</b>                                                              |                                                                                        |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ABDOMINAL SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.               |  |                                                                                                                                                    |                                                                   |                                                                                                                                                             |                                                                                        |                                                                                                 |                                                           |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>PULMONARY EMBOLISM; ANGINA 2° UPPER G.I. BLEED; MYASTHENIA GRAVIS</b>                                                                                                                                                          |  |                                                                                                                                                    |                                                                   |                                                                                                                                                             |                                                                                        |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION<br><b>10-15-87</b>                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>INSERTION OF INFUSOR VENA CATHETER<br/>2° PULMONARY EMBOLISM FULG BLED</b>                  |                                                                   |                                                                                                                                                             |                                                                                        | 20a. AUTOPSY?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO            |                                                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                  |                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                        |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                             |                                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                        |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-12</b> , 19 <b>87</b> , to <b>10-22</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>10-22</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                    |                                                                   |                                                                                                                                                             |                                                                                        |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>Orlando B. Conaway MD</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                    |                                                                   |                                                                                                                                                             | DEGREE<br><b>MD</b>                                                                    |                                                                                                 |                                                           | 22c. DATE SIGNED<br><b>10-22-87</b>                                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ORLANDO B. CONAWAY MD</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                    |                                                                   |                                                                                                                                                             | 22e. ADDRESS<br><b>PEGH - RANDALLSTOWN, Md. 21133</b>                                  |                                                                                                 |                                                           |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>10-23-87</b>                                                                                                                       |                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Carroll Cremation Ser.</b>                                                                                         |                                                                                        | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hamstead Carroll MD</b>                        |                                                           |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>NAME <b>HAIGHT FUNERAL HOME</b> ADDRESS <b>SYKESVILLE, MD 21784</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                                    |                                                                   |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1987</b>                                    |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Deaton-Randall</b> |                                                                                                                            |                                              |

BP \_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. This permit remains the property of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMM - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                         |  |  |  |  |                                                                     |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|---------------------------------------------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | REG. NO.                                                            |  |  |  |  |
| 2. DECEASED NAME<br>(Type or Print)                                                                                                                                                                                                                                                                                                                          |  |  |  |  | 2a. DATE OF DEATH                                                   |  |  |  |  |
| Doris L. Riston                                                                                                                                                                                                                                                                                                                                              |  |  |  |  | 10 23 87                                                            |  |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | 4. RACE                                                             |  |  |  |  |
| Female                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | White                                                               |  |  |  |  |
| 5. DATE OF BIRTH                                                                                                                                                                                                                                                                                                                                             |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  |  |  |
| June 2, 1927                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  | 60                                                                  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                    |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                        |  |  |  |  |
| West Virginia                                                                                                                                                                                                                                                                                                                                                |  |  |  |  | U.S.A.                                                              |  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  |  |  |
| Towson                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | Singer                                                              |  |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                                                                                                                                                                                                                                       |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |
| Greater Baltimore Medical Center                                                                                                                                                                                                                                                                                                                             |  |  |  |  | Entertainment                                                       |  |  |  |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                   |  |  |  |  | 13b. COUNTY                                                         |  |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  | Baltimore                                                           |  |  |  |  |
| 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                                                                            |  |  |  |  | 13d. INSIDE CITY LIMITS?                                            |  |  |  |  |
| 21234                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                            |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                            |  |  |  |  |
| Earl Walker                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  | Ted Wolfe                                                           |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                            |  |  |  |  | 16b. SOCIAL SECURITY NO.                                            |  |  |  |  |
| No                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  | 236-38-0400                                                         |  |  |  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                |  |  |  |  | ADDRESS                                                             |  |  |  |  |
| Peggy Ann Brewer Balto., MD                                                                                                                                                                                                                                                                                                                                  |  |  |  |  | 21234                                                               |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                        |  |  |  |  |                                                                     |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>                                                                                                                                                                                                                                                                                                          |  |  |  |  |                                                                     |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Cardiac Failure</u>                                                                                                                                                                                                                                                                                         |  |  |  |  |                                                                     |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                                                                                                                                                     |  |  |  |  |                                                                     |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                       |  |  |  |  |                                                                     |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  |  |
| 20a. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?     |  |  |  |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  |  |  |  | 21b. TIME OF INJURY                                                 |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  | HOUR A.M. MONTH DAY YEAR                                            |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  | P.M. 19                                                             |  |  |  |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                         |  |  |  |  | 21e. PLACE OF INJURY                                                |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                         |  |  |  |  | AT HOME STREET FACTORY, OFFICE, FARM, ETC                           |  |  |  |  |
| 21f. LOCATION                                                                                                                                                                                                                                                                                                                                                |  |  |  |  | CITY OR TOWN COUNTY STATE                                           |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 22, 19 87</u> , to <u>October 23, 19 87</u> , that (I) (we) last saw the deceased alive on <u>October 23, 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  | 22c. DATE SIGNED                                                    |  |  |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                               |  |  |  |  | DEGREE                                                              |  |  |  |  |
| <u>Alban Bacchus</u>                                                                                                                                                                                                                                                                                                                                         |  |  |  |  | M.D.                                                                |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                        |  |  |  |  | 22e. ADDRESS                                                        |  |  |  |  |
| Alban Bacchus, M.D.                                                                                                                                                                                                                                                                                                                                          |  |  |  |  | G.B.M.C.                                                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                    |  |  |  |  | 23b. DATE                                                           |  |  |  |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | OCT. 27, '87                                                        |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                                                                                                                                                                           |  |  |  |  | 23d. LOCATION                                                       |  |  |  |  |
| GLEN HAVEN MEM. PARK                                                                                                                                                                                                                                                                                                                                         |  |  |  |  | CITY OR TOWN COUNTY STATE                                           |  |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                         |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |  |  |  |
| WILLIAM E. JOHNSON                                                                                                                                                                                                                                                                                                                                           |  |  |  |  | OCT 26 1987                                                         |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                   |  |  |  |  | 25c. REGISTRAR'S NAME                                               |  |  |  |  |
| <u>Julia R. ...</u>                                                                                                                                                                                                                                                                                                                                          |  |  |  |  | ANNE ARUNDEL CO., MD                                                |  |  |  |  |



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                               |  |                                                                                                                                                            |                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1 DECEASED NAME<br>FIRST <b>Robert</b> MIDDLE <b>L.</b> LAST <b>Ritter</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2a DATE OF DEATH MONTH <b>10</b> DAY <b>24</b> YEAR <b>87</b>                 |  | 2b HOUR <b>1:50</b> AM                                                                                                                                     |                                                       |
| 3 SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4 RACE <b>White</b>                                                           |  | 5 DATE OF BIRTH MONTH <b>1</b> DAY <b>7</b> YEAR <b>01</b>                                                                                                 |                                                       |
| 6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>                                   |  | IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>                                                                                                                 |                                                       |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>                                        |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                       |
| 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10 CITY OR TOWN OF DEATH <b>Parkville</b>                                     |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Perring Parkway Nursing Home</b>                  |                                                       |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12b KIND OF BUSINESS OR INDUSTRY <b>Black &amp; Decker</b>                    |  |                                                                                                                                                            |                                                       |
| 13a STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b COUNTY <b>Baltimore</b>                                                   |  | 13c CITY OR TOWN <b>Parkville</b>                                                                                                                          |                                                       |
| 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13e STREET ADDRESS / ZIP CODE <b>Perring Pkwy. &amp; Oakleigh Rd., 21234</b>  |  |                                                                                                                                                            |                                                       |
| 14 FATHER'S NAME FIRST <b>Alfred</b> MIDDLE <b>G.</b> LAST <b>Ritter, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 15 MOTHER'S MAIDEN NAME FIRST <b>Francis</b> MIDDLE <b></b> LAST <b>Cross</b> |  |                                                                                                                                                            |                                                       |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b SOCIAL SECURITY NO. <b>212-10-9644</b>                                    |  | 17 INFORMANT ADDRESS <b>James H. Ritter, 106 Belfast Rd., 21093</b>                                                                                        |                                                       |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adeno-CARCINOMA of Prostate 7 YRS-</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CANCER-Metastases-</b><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>HAS CVD, MYOCARDIAL INFARCTION - C.V.A.</b> |  |                                                                               |  |                                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>-</b> |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |                                                       |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                               |  |                                                                                                                                                            |                                                       |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                 |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1/16 81</b>                    |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                       |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                                                                            |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                       |
| 22a I certify that (I) (this hospital) attended the deceased from <b>1/16 81</b> to <b>10/24 87</b> , that (I) (we) last saw the deceased alive on <b>10/24 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                 |  |                                                                               |  |                                                                                                                                                            |                                                       |
| 22b SIGNATURE <b>Anthony F. Carozza MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | DEGREE <b>MD</b>                                                              |  | 22c DATE SIGNED <b>10/24/87</b>                                                                                                                            |                                                       |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTHONY F. CAROZZA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 22e ADDRESS <b>4214 MANORWOOD DR GLEN ARMY MD</b>                             |  |                                                                                                                                                            |                                                       |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b DATE <b>10/27/87</b>                                                      |  | 23c NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Mausoleum</b>                                                                                             |                                                       |
| 23d LOCATION CITY OR TOWN <b>Pikesville</b> COUNTY <b>Balto.</b> STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                               |  |                                                                                                                                                            |                                                       |
| 24 FINAL DIRECTOR <b>Bryan W. Clary</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | ADDRESS <b>10 W. Padonia Rd. 21093</b>                                        |  | 25a DATE REG'D BY REGISTRAR <b>OCT 28 1987</b> 25b REGISTRAR'S SIGNATURE                                                                                   |                                                       |

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1 - FOR  
07 STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH


REG. NO.

|                                                                                              |  |                                                                                                        |  |                  |  |                                                                                                                                                          |  |                                 |  |                                      |  |                                                                     |  |                            |  |                                   |  |  |  |
|----------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|--|--------------------------------------|--|---------------------------------------------------------------------|--|----------------------------|--|-----------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                          |  | FIRST                                                                                                  |  | MIDDLE           |  | LAST                                                                                                                                                     |  | 2a. DATE OF DEATH               |  | MONTH                                |  | DAY                                                                 |  | YEAR                       |  | 2b. HOUR                          |  |  |  |
| Margaret C. Ritterpusch                                                                      |  |                                                                                                        |  |                  |  |                                                                                                                                                          |  | October 28 1987                 |  |                                      |  |                                                                     |  |                            |  |                                   |  |  |  |
| 3. SEX                                                                                       |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH |  |                                                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  |                                      |  | IF UNDER 1 YEAR                                                     |  |                            |  | IF UNDER 24 HRS.                  |  |  |  |
| FEMALE                                                                                       |  | WHITE                                                                                                  |  | JUN 20, 1906     |  |                                                                                                                                                          |  | 81                              |  |                                      |  | MONTHS                                                              |  |                            |  | DAYS                              |  |  |  |
|                                                                                              |  |                                                                                                        |  |                  |  |                                                                                                                                                          |  | YRS.                            |  |                                      |  | HOURS                                                               |  |                            |  | MIN.                              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  |                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                                                     |  |                            |  |                                   |  |  |  |
| Maryland                                                                                     |  | U.S.A.                                                                                                 |  |                  |  |                                                                                                                                                          |  |                                 |  | Baltimore County MD                  |  |                                                                     |  |                            |  |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                  |  |                                                                                                                                                          |  |                                 |  |                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |                            |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Towson                                                                                       |  | ST. Joseph Hospital                                                                                    |  |                  |  |                                                                                                                                                          |  |                                 |  |                                      |  | SELF-EMP.                                                           |  |                            |  | STORE                             |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |                                                                                                        |  |                  |  |                                                                                                                                                          |  |                                 |  | 13b. STATE                           |  | 13c. CITY OR TOWN                                                   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS / ZIP CODE    |  |  |  |
| Maryland                                                                                     |  |                                                                                                        |  |                  |  |                                                                                                                                                          |  |                                 |  | Baltimore                            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 21239 6401 Loch Raven Blvd |  |                                   |  |  |  |
| 14. FATHER'S NAME                                                                            |  | FIRST                                                                                                  |  | MIDDLE           |  | LAST                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME        |  |                                      |  |                                                                     |  |                            |  |                                   |  |  |  |
| John                                                                                         |  | C.                                                                                                     |  | Brunnett         |  | Margaret Linker                                                                                                                                          |  |                                 |  |                                      |  |                                                                     |  |                            |  |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                            |  |                                                                                                        |  |                  |  | 16b. SOCIAL SECURITY NO.                                                                                                                                 |  |                                 |  |                                      |  | 17. INFORMANT                                                       |  |                            |  |                                   |  |  |  |
| NO                                                                                           |  |                                                                                                        |  |                  |  | 216203499                                                                                                                                                |  |                                 |  |                                      |  | Family Records                                                      |  |                            |  |                                   |  |  |  |

|                                                                                                                                                                                                                                                                                                                                                        |  |                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| <b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c).<br><b>PART 1. DEATH WAS CAUSED BY:</b><br>IMMEDIATE CAUSE (a) <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Peritonitis, localized, with large abscess formation.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>walled off perforation of stomach</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                         |  |                                                 |
| <b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:</b>                                                                                                                                                                                                                |  |                                                 |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

## MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |                                                                                                                                            |                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       | 20b. IF YES, HOW FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                              |                                                                                                                                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                                                      |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |                                                                        |                                                                                                                                            |                                                                                                                                      |
| 22b. SIGNATURE<br>                                                                                                                                                                                                                                                             | DEGREE                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>10-29-87                                                                                                         |
| 27a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>REYNALDO R. KELEA-GONZALEZ, M.D.                                                                                                                                                                                                                                                                                         | 27b. ADDRESS                                                           |                                                                                                                                            |                                                                                                                                      |

|                                           |                              |                                   |                              |        |          |
|-------------------------------------------|------------------------------|-----------------------------------|------------------------------|--------|----------|
| 23a BURIAL, CREMATION, REMOVAL<br>SPECIFY | 23b DATE                     | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION<br>CITY OR TOWN | COUNTY | STATE    |
| BURIAL                                    | 10 31 1987                   | LOVEDAY PARK                      | BALTIMORE                    |        | MARYLAND |
| 24 FUNERAL DIRECTOR<br>NAME               | 25a DATE REC'D. BY REGISTRAR | 25b REGISTRAR'S SIGNATURE         |                              |        |          |
| EVANS CHAPEL OF MEMORIES ROAD<br>ADDRESS  | NOV 5 1987                   | Frederick R. Pender               |                              |        |          |

BP\_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

4/

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4-82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                       |                                                   |                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ARTHUR Gilbert ROBERTS</b>                                                                                                                                                                                                                                                                                                                                                                                |                         | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>10 21 19 87</b> |                                                   | 2b. HOUR<br><b>0830</b>                                                                                                                                     |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>June</b> DAY <b>1</b> YEAR <b>14</b>                                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73 YRS.</b> | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>                                                                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                     |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                            |                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                                                                                                                                                                                                                                                                                                                                                                                  |                         | 10. DATE PRONOUNCED DEAD<br>MONTH <b>10</b> DAY <b>21</b> YEAR <b>19 87</b>                                                                           |                                                   | 11. HOUR<br><b>1230</b>                                                                                                                                     |
| 12. CITY OR TOWN OF DEATH<br><b>Dundalk</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                         | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2008 Merritt Avenue</b>              |                                                   | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steel Worker</b>                                                                         |
| 15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE <b>Maryland</b> 15b. COUNTY <b>Baltimore</b> 15c. CITY OR TOWN <b>Arbutus</b>                                                                                                                                                                                                                                                       |                         | 16. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                        |                                                   | 17. STREET ADDRESS<br><b>1001 Leeds Avenue, 21229</b>                                                                                                       |
| 18. FATHER'S NAME<br>FIRST <b>Herbert</b> MIDDLE <b>A.</b> LAST <b>Roberts</b>                                                                                                                                                                                                                                                                                                                                                                   |                         | 19. MOTHER'S MAIDEN NAME<br>FIRST <b>Emma</b> MIDDLE <b>A.</b> LAST <b>Kendall</b>                                                                    |                                                   |                                                                                                                                                             |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW II</b>                                                                                                                                                                                                                                                                                                                         |                         | 21. SOCIAL SECURITY NO.<br><b>216-18-0421</b>                                                                                                         |                                                   | 22. INFORMANT ADDRESS<br><b>Gilbert G. Roberts, 1001 Leeds Avenue</b>                                                                                       |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |                         |                                                                                                                                                       |                                                   |                                                                                                                                                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                                                       |                                                   |                                                                                                                                                             |
| 24. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                            |                         | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                      |                                                   | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                         |
| 27. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                            |                         | 28. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                                                                                      |                                                   | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                                |
| 30. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                    |                         | 31. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                                                                            |                                                   | 32. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                                   |
| 33. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                         |                                                                                                                                                       |                                                   |                                                                                                                                                             |
| 34. ACTUAL SIGNATURE<br><b>J. Crossan O'Donoghue</b>                                                                                                                                                                                                                                                                                                                                                                                             |                         | 35. TITLE (SPECIFY)<br><b>Deputy</b>                                                                                                                  |                                                   | 36. MEDICAL EXAMINER<br>DATE SIGNED <b>10/21/87</b>                                                                                                         |
| 37. EXAMINER'S NAME<br>(TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>                                                                                                                                                                                                                                                                                                                                                                               |                         | 38. ADDRESS<br><b>2112 Dundalk Ave., Balto., Md. 21222</b>                                                                                            |                                                   |                                                                                                                                                             |
| 39. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                     |                         | 40. DATE<br><b>10/24/87</b>                                                                                                                           |                                                   | 41. NAME OF CEMETERY OR CREMATORY<br><b>Security Process Crem.</b>                                                                                          |
| 42. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Baltimore Md.</b>                                                                                                                                                                                                                                                                                                                                                                    |                         | 43. FUNERAL DIRECTOR<br>NAME <b>Hubbard Funeral Home, Inc., 4107 Wilkens Ave.</b> ADDRESS <b>21229</b>                                                |                                                   | 44. DATE RECD. BY REGISTRAR<br><b>OCT 23 1987</b>                                                                                                           |
| 45. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Landauer</b>                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                                       |                                                   |                                                                                                                                                             |

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RECEIVED

NOV 1 1987



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                       |                                                                                                                                                            |                                                                            |                                                                                                | REG. NO.                                                                                                                             |                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Nancy Lee ROBINSON                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                       |                                                                                                                                                            |                                                                            | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>October 5, 1987                                          |                                                                                                                                      | 2b HOUR<br>5:25p M                                              |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4 RACE<br>White                                                                                                                       | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 17 41                                                                                                              |                                                                            | 6 AGE (IN YEARS (LAST BIRTHDAY))<br>45 YRS                                                     |                                                                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                 | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                            | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |                                                                                                                                      |                                                                 |
| 10 CITY OR TOWN OF DEATH<br>Essex                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |                                                                                                                                                            | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cashier |                                                                                                | 12b KIND OF BUSINESS OR INDUSTRY<br>Grocery Store                                                                                    |                                                                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                       | 13b COUNTY<br>Baltimore                                                                                                                                    | 13c CITY OR TOWN<br>Middle River                                           | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE<br>1619 D. Rickenbacker Rd. 21221                                                                      |                                                                 |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wilbur Johnson                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                       | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Conlon                                                                                                |                                                                            |                                                                                                |                                                                                                                                      |                                                                 |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                       | 16b SOCIAL SECURITY NO.<br>220-36-7422                                                                                                                     |                                                                            | 17 INFORMANT ADDRESS<br>Kimberly Dodd 9811-B langs Rd. 21221                                   |                                                                                                                                      |                                                                 |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute pulmonary embolus of right lower lobe of lung with infarction.</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomegaly with old myocardial infarction and possible acute extension.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last        |                                                                                                                                       |                                                                                                                                                            |                                                                            |                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                         |                                                                 |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                       |                                                                                                                                                            |                                                                            |                                                                                                |                                                                                                                                      |                                                                 |
| 19a DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                       | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                            | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                 |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                |                                                                                                                                       | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                            | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                  |                                                                                                                                      |                                                                 |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                       | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                            | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                                      |                                                                 |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 30, 1987</u> to <u>October 5, 1987</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 5, 1987</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |                                                                                                                                       |                                                                                                                                                            |                                                                            |                                                                                                |                                                                                                                                      |                                                                 |
| 22b SIGNATURE<br><u>A.A. Richards MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                       | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |                                                                            | 22c DATE SIGNED<br>10/5/87                                                                     |                                                                                                                                      |                                                                 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Richards MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                       | 22e ADDRESS<br>9000 Franklin Square Dr., Balto., 21237                                                                                                     |                                                                            |                                                                                                |                                                                                                                                      |                                                                 |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                 | 23b DATE<br>10/9/87                                                                                                                   | 23c NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery                                                                                                   |                                                                            | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn Pk. A.A. Maryland                        |                                                                                                                                      |                                                                 |
| 24 FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                       | 24b ADDRESS<br>21229<br>4107 Wilkens Ave.                                                                                                                  |                                                                            | 25a DATE REC'D. BY REGISTRAR<br>25b REGISTRAR'S SIGNATURE<br>OCT 09 1987 <u>Julia Davidson</u> |                                                                                                                                      |                                                                 |

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067666 OCT 16 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 94 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                               |                                                                           |                                                                                                                                                             |                                                                                  |                                                                                      |                                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELIZABETH ROEMER</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                               | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 2, 1987</b>                |                                                                                                                                                             | 2b. HOUR<br><b>3:40 P.M.</b>                                                     |                                                                                      |                                                                                                 |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>White</b>                                                                                                                       |                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 8, 1896</b>                                                                                                   |                                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS                                     |                                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Ruxton</b>                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Nursing Center</b> |                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bookkeeper</b>                                                                       |                                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Warehouse</b>                                |                                                                                                 |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               | 13b. COUNTY<br><b>Baltimore</b>                                           |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Rogers Forge</b>                                         |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Roemer</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary R. HEINEMANN</b> |                                                                                                                                                             |                                                                                  |                                                                                      |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><b>212-10-5543</b>                            |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>William Roemer 17000 Gerting Rd. Monkton 2111</b> |                                                                                      |                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHRONIC ARTERIOSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |                                                                                                                                               |                                                                           |                                                                                                                                                             |                                                                                  |                                                                                      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 Days</b><br><b>YEARS</b>               |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                               |                                                                           |                                                                                                                                                             |                                                                                  |                                                                                      |                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |                                                                                                                                                             |                                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                           |  |                                                                                                                                               |                                                                           |                                                                                                                                                             |                                                                                  |                                                                                      |                                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                 |  |                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)    |                                                                                      |                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                            |  |                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |                                                                                      |                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/2</b> , 19 <b>87</b> , to <b>10/2</b> , 19 <b>87</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/2</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                |  |                                                                                                                                               |                                                                           |                                                                                                                                                             |                                                                                  |                                                                                      |                                                                                                 |  |
| 22b. SIGNATURE<br><b>M. W. Williams</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                               | DEGREE<br><b>M.D.</b>                                                     |                                                                                                                                                             |                                                                                  | 22c. DATE SIGNED<br><b>10/2/87</b>                                                   |                                                                                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Myron W. Williams</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                               | 22e. ADDRESS<br><b>201 E. University Parkway, BALTO 21218</b>             |                                                                                                                                                             |                                                                                  |                                                                                      |                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                               | 23b. DATE<br><b>10/05/87</b>                                              |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>                    |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |
| 24. FUNERAL DIRECTOR<br><b>LeRoy M. &amp; Russell C. Witzke</b><br><b>1630 Edmondson Ave. Catonsville MD 21228</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                               |                                                                           |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 05 1987</b>                              |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>John Swanson-Randall</b>                                       |  |

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other transmission event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                           |  |                                                                                                                                |  | REG. NO. 87 28255                                                                                                                                           |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DOMINICK A. ROMEO                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 6, 1987                                                                                                      |  |                                                                                                                            |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                |  | 2b. HOUR<br>6:30A <sub>M</sub>                                                                                                                              |  |                                                                                                                            |  |
| 4. RACE<br>WHITE                                                                                                                                                                                                                                                                                                                                                               |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOVEMBER 1, 1910                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.                                                                                                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tractor trailer                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dr. Hauling                                                                           |  |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>BALTIMORE                                                                                                       |  | 13c. CITY OR TOWN<br>BALTO MD                                                                                                                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH ----- ROMEO                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY ----- REALI                                                              |  | 13e. STREET ADDRESS / ZIP CODE<br>1308 WILLIAM STREET 21230                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>PRE KOREAN                                                          |  | 17. INFORMANT<br>CLINICAL RECORDS, VAMC, FORT HOWARD                                                                                                        |  | ADDRESS                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>GASTROINTERNAL BLEEDING</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RENAL FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST  |  |                                                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 DAYS                                                                                                      |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>ASCVD, COPD</u>                                                                                                                                                                                                                       |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 1</u> , 19 <u>87</u> , to <u>OCTOBER 6</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>OCTOBER 6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                |  |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>C. Custodio, M.D.</u>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>10-6-87                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CAROLINA C. CUSTODIO, M.D.                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                |  | 22e. ADDRESS<br>VA MEDICAL CENTER FORT HOWARD, MD                                                                                                           |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>10/9/87                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Mem.                                                                                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium Balto. Co. Md.                                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME Balto, Md. 21230<br>McCully Funeral Home, 130 E. Fort Ave.                                                                                                                                                                                                                                                                                        |  |                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 6 1987                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Tendon-Land                                                                            |  |

087630 OCT-80

ON LINE  
10/20/80

067831 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                     |  |                                                                                                           |                   |                                                                                                                                                             |  |                                                                     |  |                                                                |                                   | REG. NO.                                     |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|----------------------------------------------------------------|-----------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           | FIRST MIDDLE LAST |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR                                 |  |                                                                | 2b. HOUR<br>MIN.                  |                                              |  |
| JULIUS                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           | ROSE              |                                                                                                                                                             |  | OCTOBER 2, 1987                                                     |  |                                                                | 3:40 <sup>A</sup>                 |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE                                                                                                   |                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |                                   | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| MALE                                                                                                                                                                                                                                                                                                                                                                     |  | WHITE                                                                                                     |                   | JULY 3, 1911                                                                                                                                                |  | 76 YRS.                                                             |  |                                                                |                                   |                                              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                                                |                                   |                                              |  |
| NEW YORK                                                                                                                                                                                                                                                                                                                                                                 |  | U.S.A.                                                                                                    |                   |                                                                                                                                                             |  | BALTIMORE COUNTY MD.                                                |  |                                                                |                                   |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  |                                                                | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |
| FORT HOWARD                                                                                                                                                                                                                                                                                                                                                              |  | VA MEDICAL CENTER                                                                                         |                   |                                                                                                                                                             |  | Conservation Officer                                                |  |                                                                |                                   |                                              |  |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |                   | 13b. COUNTY                                                                                                                                                 |  | 13c. CITY OR TOWN                                                   |  | 13d. INSIDE CITY LIMITS?                                       |                                   | 13e. STREET ADDRESS / ZIP CODE               |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                 |  | HOWARD                                                                                                    |                   | ELLICOTT CITY                                                                                                                                               |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 9850 MICHAELS WAY 21043                                        |                                   |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                                                                               |  |                                                                     |  |                                                                |                                   |                                              |  |
| JULIUS ROSE                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |                   | MARGARET BOBEL                                                                                                                                              |  |                                                                     |  | BOBEL                                                          |                                   |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |                   | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT ADDRESS                                               |  |                                                                |                                   |                                              |  |
| YES                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |                   | WWII                                                                                                                                                        |  | 093 05 8210 CLINICAL RECORDS, VAMC, FORT HOWARD                     |  |                                                                |                                   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                           |                   |                                                                                                                                                             |  |                                                                     |  |                                                                |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>ORGANIC BRAIN SYNDROME, ATRIAL FIBILLATION, ASCVD</u>                                                                                                                                                                                |  |                                                                                                           |                   |                                                                                                                                                             |  |                                                                     |  |                                                                |                                   |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                   |                                                                                                                                                             |  | 20a. AUTOPSY?                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |                   |                                                                                                                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                     |  |                                                                |                                   |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |                                                                |                                   |                                              |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 30, 1987</u> , to <u>OCTOBER 2, 1987</u> , that (I) (we) lost saw the deceased alive on <u>OCTOBER 2, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |                                                                                                           |                   |                                                                                                                                                             |  |                                                                     |  |                                                                |                                   |                                              |  |
| 22b. SIGNATURE<br><u>B. Custodio, M.D.</u>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |                   | DEGREE                                                                                                                                                      |  |                                                                     |  | 22c. DATE SIGNED                                               |                                   |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |                   | 22e. ADDRESS                                                                                                                                                |  |                                                                     |  |                                                                |                                   |                                              |  |
| CAROLINA C. CUSTODIO, M.D.                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                           |                   | VA MEDICAL CENTER FORT HOWARD, MD 21052                                                                                                                     |  |                                                                     |  |                                                                |                                   |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                                                 |                   | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                                                                |                                   |                                              |  |
| Removal                                                                                                                                                                                                                                                                                                                                                                  |  | 10/2/87                                                                                                   |                   | Paige Cemetery                                                                                                                                              |  | Downtown Delaware New York                                          |  |                                                                |                                   |                                              |  |
| 24. FUNERAL DIRECTOR<br>ConnellyFuneralHome of Dundalk 21222                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |                   |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |                                   |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |                   |                                                                                                                                                             |  | OCT 6 1987                                                          |  | <u>Julia Davidson</u>                                          |                                   |                                              |  |

005031 OCT-78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. The medical examiner must be notified of one.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          |                                       |                                                                                                                                                                                                                                                                                                                                   | REG. NO. 87 28257 |                                                                                                 |                  |                                                              |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          | 2a. DATE OF DEATH                     |                                                                                                                                                                                                                                                                                                                                   | MONTH DAY YEAR    |                                                                                                 | 2b. HOUR         |                                                              |                                                                                                                            |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>VINCENT J. ROSE, SR.                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          | 2a. DATE OF DEATH<br>OCTOBER 20, 1987 |                                                                                                                                                                                                                                                                                                                                   | MONTH DAY YEAR    |                                                                                                 | 2b. HOUR<br>AM   |                                                              |                                                                                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>White                                                                                                                         |                                       | 5. DATE OF BIRTH<br>June 14, 1913                                                                                                                                                                                                                                                                                                 |                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74                                                           |                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                    |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                   |                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                       |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |                  |                                                              |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>21234                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6819 Collinsdale Road 21234 |                                       |                                                                                                                                                                                                                                                                                                                                   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor                  |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Frd. Govt.              |                                                                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br>Baltimore                                                                                                                 |                                       | 13c. CITY OR TOWN<br>21234                                                                                                                                                                                                                                                                                                        |                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  | 13e. STREET ADDRESS / ZIP CODE<br>6819 Collinsdale Rd. 21234 |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank Rose                                                                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rose Pizza                                                                              |                                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                                           |                   |                                                                                                 |                  |                                                              | 16b. SOCIAL SECURITY NO.<br>220-07-3529                                                                                    |  |
| 17. INFORMANT<br>Sarah P. Rose                                                                                                                                                                                                                                                                                                                                                                                                    |  | 17. ADDRESS<br>6819 Collinsdale Rd.                                                                                                      |                                       | 21a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |                   |                                                                                                 |                  |                                                              | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PROBABLE MI<br>DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Myocardial Vascular disease / Diabetes |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                             |                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                         |                   |                                                                                                 |                  |                                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                               |                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                                                    |                   |                                                                                                 |                  |                                                              | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                                                            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                        |                                       | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased above on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                   |                                                                                                 |                  |                                                              | 22b. SIGNATURE<br>DEGREE<br>Roy H. Phillips, M.D.                                                                          |  |
| 22c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22d. ADDRESS<br>2005- Rock Spring Rd. 838-9080                                                                                           |                                       |                                                                                                                                                                                                                                                                                                                                   |                   |                                                                                                 | 22e. DATE SIGNED |                                                              | 22f. SIGNATURE<br>DEGREE<br>Roy H. Phillips, M.D.                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>Oct. 24, '87                                                                                                                |                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEMETERY                                                                                                                                                                                                                                                                           |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CO., MARYLAND                           |                  |                                                              |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WILLIAM E. JOHNSON                                                                                                                                                                                                                                                                                                                                                                                |  | 24. ADDRESS<br>8521 LOCH RAVEN BLVD.                                                                                                     |                                       | 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1987                                                                                                                                                                                                                                                                                      |                   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                       |                  |                                                              |                                                                                                                            |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                                                   |                                                                                                  |                                                                              |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>MYRTLE I. ROSENBERGER</i>                                                                                                                                                                                                                                                                  |  |                                                                                                                                                         | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10 / 2 / 87</i>                 |                                                                                                                                                            |                                                                                   | 2b. HOUR<br><i>12 30 PM</i>                                                                      |                                                                              |                                                                                                                               |  |
| 3 SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                            |  | 4 RACE<br><i>White</i>                                                                                                                                  |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2 4 95</i>                                                                                                        |                                                                                   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>92</i> YRS                                                  |                                                                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                           |                                                                        | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                               |                                                                              |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Meridian Nursing Center-Valley View</i> |                                                                        |                                                                                                                                                            |                                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>             |                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>-</i>                                                                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                           |  |                                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                                                   |                                                                                                  |                                                                              |                                                                                                                               |  |
| 13a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><i>Baltimore</i>                                                                                                                         |                                                                        | 13c. CITY OR TOWN<br><i>Baltimore</i>                                                                                                                      |                                                                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                                                              | 13e. STREET ADDRESS / ZIP CODE<br><i>1738 Leslie Road 21222</i>                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Martin David Lau</i>                                                                                                                                                                                                                                                                 |  |                                                                                                                                                         |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Hattie Moore</i>                                                                                       |                                                                                   |                                                                                                  |                                                                              |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>                                                                                                                                                                                                                     |  |                                                                                                                                                         |                                                                        | 16b. SOCIAL SECURITY NO.<br><i>218-22-9558</i>                                                                                                             |                                                                                   | 17 INFORMANT ADDRESS<br><i>Mr. Anthony Saladino, 2708 Moorgate Road<br/>Baltimore, Md. 21222</i> |                                                                              |                                                                                                                               |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ischemic Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Parkinson's Disease</i>                            |  |                                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                                                   |                                                                                                  |                                                                              |                                                                                                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>-</i>                                                                                                                                                                                          |  |                                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                                                   |                                                                                                  |                                                                              |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                            |                                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |                                                                              | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  |                                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                            | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                  |                                                                              |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                      |  |                                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |                                                                                                  |                                                                              |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                                                   |                                                                                                  |                                                                              |                                                                                                                               |  |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                         |                                                                        | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |                                                                                   |                                                                                                  |                                                                              | 22c. DATE SIGNED<br><i>10/2/87</i>                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>K. P. A. C. H. P. A. T. R. I. C. I. O.</i>                                                                                                                                                                                                                                            |  |                                                                                                                                                         |                                                                        | 22e. ADDRESS<br><i>703 S. Clinton St. 21224</i>                                                                                                            |                                                                                   |                                                                                                  |                                                                              |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                     |  |                                                                                                                                                         | 23b. DATE<br><i>10-5-87</i>                                            |                                                                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holly Hill Mem. Park</i>                 |                                                                                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Baltimore Md.</i> |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Ann S. Matthews, Matthews Funeral Home<br/>3021 Eastern Avenue, Baltimore, Md. 21224</i>                                                                                                                                                                                               |  |                                                                                                                                                         |                                                                        |                                                                                                                                                            |                                                                                   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 6 1987</i>                                               |                                                                              | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Swenson-Randall</i>                                                                    |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 should be detached for use as the burial-transit permit. Then please remove the remaining pages. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1876-1880 010731



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on this 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  | REG. NO.                                                                                                                                                          |  |                                                                                                                         |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |  | 7 28259                                                                                                                                                           |  |                                                                                                                         |                                              |
| 1. DECEASED NAME (LAST OR PRINT) FIRST MIDDLE LAST<br><b>JAMES NOLAN ROSS</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 27, 1987</b>                                                                                                       |  | 2b. HOUR<br><b>11:05 PM</b>                                                                                             |                                              |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>BLACK</b>                                                                                                              |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>OCTOBER 3, 1917</b>                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>70 YRS</b>                                                            |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                        |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                                                     |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>V.A. MEDICAL CENTER</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FIREMAN</b>                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                       |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br><b>MARYLAND PRINCE GEORGE'S BELTSVILLE</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                      |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                      |  | 13e. STREET ADDRESS<br><b>6149 ODELL ROAD/20705</b>                                                                     |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HARRY ROSS</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ELIZABETH MILLER</b>                                                                                             |  |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATS)<br><b>W.W. II</b>                                                                |  | 17. INFORMANT ADDRESS<br><b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD.</b>                                                                                          |  |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>POSSIBLE LUNG CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>METASTATIC TUMOR TO BRAIN</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |                                                                                                                                      |  |                                                                                                                                                                   |  |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                    |  |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                    |  |                                                                                                                         |                                              |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>OCTOBER 26, 19 87</b> , to <b>OCTOBER 27, 19 87</b> , that (X) (we) lost the deceased alive on <b>OCTOBER 27, 19 87</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.                                                                                         |  |                                                                                                                                      |  |                                                                                                                                                                   |  |                                                                                                                         |                                              |
| 22b. SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/27/87</b>                                                                                     |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JULIN TANG, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                      |  | 22e. ADDRESS<br><b>VAMC, FORT HOWARD, MD. 21052</b>                                                                                                               |  |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>Oct 29'87</b>                                                                                                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Pk.</b>                                                                                                |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Catonsville Balto. Maryland</b>                                           |                                              |
| 24. FUNERAL DIRECTOR NAME<br><b>Harry H Witzke Funeral Home Inc</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1987</b>                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                        |                                              |
| 4112 Old Columbia Pike Ellicott City                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                                                                                   |  |                                                                                                                         |                                              |

13 06 199 1 7 3 0 70

13 06 199

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                     |                                                         |                                                                                                                                                             |  |                                                                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Theodore Leo Rossman, Sr.                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 27, 1987 |                                                                                                                                                             |  | 2b. HOUR<br>11A M                                                                                                                               |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>White                                                                                                                    |                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 10, 1897                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90<br>YRS.                                                                                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              |                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Lutherville                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1710 Greenspring Drive |                                                         |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Musician                                                                    |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br>Baltimore                                                                                                            |                                                         | 13c. CITY OR TOWN<br>Lutherville                                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Bernard Rossman                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annlee Lee Barnes                                                                                          |  |                                                                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWI 212-09-9740                                                          |                                                         | 17. INFORMANT ADDRESS<br>Theodore Leo Rossman, Jr. Same As #13e 21093                                                                                       |  |                                                                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE: <i>acute myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <i>ischemic heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <i>hypertension</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <i>7-8</i> |  |                                                                                                                                     |                                                         |                                                                                                                                                             |  |                                                                                                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.                                                                                                                                                                                                                                |  |                                                                                                                                     |                                                         |                                                                                                                                                             |  |                                                                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |                                                         |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                       |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <i>87</i> to <i>10/28</i> 19 <i>87</i> , that (I) (we) lost<br>saw the deceased alive on <i>7/22</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) see the body after death.                |  |                                                                                                                                     |                                                         |                                                                                                                                                             |  |                                                                                                                                                 |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William Renner M.D.                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                     |                                                         | 22c. DATE SIGNED<br>10/28/87                                                                                                                                |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>10-29-87                                                                                                               |                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery                                                                                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn, Anne Arundel Md.                                                                        |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc. 1050 York Rd.<br>Towson, Md. 21204                                                                                                                                                                                                                                                         |  |                                                                                                                                     |                                                         | 25a. DATE REC'D. BY REGISTRAR<br>OCT 30 1987                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><i>Miss Davidson-Randall</i>                                                                                      |  |

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "NOTED" and "RECEIVED" are visible.]*

067422 OCT 20

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16-60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use at the burial-transit permit. Then please remove carbon papers. Page 3 and 4 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medicare carrier is notified.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                |                                                                                                                                                             |                                                                                |                                                                                      |                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DOROTHY W. ROUSSEAU                                                                                                                                                                                                                                                                           |                                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCT 01, 1987                            |                                                                                      | 2b. HOUR<br>M                             |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                     | 4. RACE<br>WHITE                                                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAR. 03, 1900                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>- 87 -<br>YRS                               |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO. MD.                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CO. MD.                         |                                                                                      |                                           |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MANOR CARE RUXTON |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ADV. CORP. |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>MARYLAND                                                                                                                                                                                                               |                                                                                                                                | 13c. CITY OR TOWN<br>PARKVILLE                                                                                                                              | 13d. STREET ADDRESS / ZIP CODE<br>2916 MANN'S AVE 21234                        |                                                                                      |                                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN WILKINSON                                                                                                                                                                                                                                                                             |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DORA SHIELDS                                                                                               |                                                                                |                                                                                      |                                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                           |                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>216-01-3997                                                                                                                     |                                                                                | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS                                           |                                           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Pneumonia of lung<br>DUE TO (b) AS A CONSEQUENCE OF Severe Chronic Obstructive lung disease and<br>DUE TO (c) Congestive heart failure & ASCVD.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                                |                                                                                                                                                             |                                                                                |                                                                                      |                                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                                                                                                                                                                                                     |                                                                                                                                |                                                                                                                                                             |                                                                                |                                                                                      |                                           |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                           |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                           |                                                                                                                                | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, FURNISH MEDICAL EXAMINER)   |                                                                                |                                                                                      |                                           |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                           |                                                                                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                |                                                                                      |                                           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                          |                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                           |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/30/87 to 10/1/87, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                            |                                                                                                                                |                                                                                                                                                             |                                                                                |                                                                                      |                                           |
| 22b. SIGNATURE<br>Frank Kasik MD                                                                                                                                                                                                                                                                                                     |                                                                                                                                | DEGREE                                                                                                                                                      |                                                                                | 22c. DATE SIGNED<br>10-03-1987                                                       |                                           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANK KASIK JR MD                                                                                                                                                                                                                                                                           |                                                                                                                                | 22e. ADDRESS<br>9005 HARFORD RD BALTO MD                                                                                                                    |                                                                                |                                                                                      |                                           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(Type)                                                                                                                                                                                                                                                                                            |                                                                                                                                | 23b. DATE<br>10-03-1987                                                                                                                                     |                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATHEDRAL                                  |                                           |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. CITY MD.                                                                                                                                                                                                                                                                        |                                                                                                                                | 24. FUNERAL DIRECTOR<br>EVANS CHAPEL OF MEMORIES ADDRESS                                                                                                    |                                                                                |                                                                                      |                                           |
| 25a. DATE REC'D. BY REGISTRAR<br>OCT 1 1987                                                                                                                                                                                                                                                                                          |                                                                                                                                | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                                                                                        |                                                                                |                                                                                      |                                           |

ON FILE



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068286 OCT 13 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 28262

REG. NO.

|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |                                                |                                                                                                                                                             |  |                                                                                                                               |                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>PAULINE S. RYDZEWSKI                                                                                                                                                                                                                                                              |  |                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 7 87 |                                                                                                                                                             |  | 2b. HOUR<br>7:25 A.M.                                                                                                         |                                                 |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>CAUCASIAN                                                                                                              |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 22 1914                                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.                                                                                    |                                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                               |                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                                  |                                                 |
| 10. CITY OR TOWN OF DEATH<br>BALTO. COUNTY                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>STELLA MARIS HOSPICE |                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FACTORY WORKER                                                                           |                                                 |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |                                                | 13b. COUNTY<br>BALTIMORE                                                                                                                                    |  | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>VINCENT                                                                                                                                                                                                                                                                        |  |                                                                                                                                   |                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DEC                                                                                                        |  |                                                                                                                               |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>219-01-3957                                                                                           |                                                | 17. INFORMANT<br>ADDRESS<br>FAMILY RECORDS                                                                                                                  |  |                                                                                                                               |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE M. I.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                               |  |                                                                                                                                   |                                                |                                                                                                                                                             |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                      |  |                                                                                                                                   |                                                |                                                                                                                                                             |  |                                                                                                                               |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                               |                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                               |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 28, 1979, to OCTOBER 7, 1987, that (I) (we) last saw the deceased alive on 9-11-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                   |                                                |                                                                                                                                                             |  |                                                                                                                               |                                                 |
| 22b. SIGNATURE<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                   |  |                                                                                                                                   |                                                | 22c. DATE SIGNED<br>OCT. 7, 1987                                                                                                                            |  |                                                                                                                               |                                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                    |  |                                                                                                                                   |                                                | 22e. ADDRESS                                                                                                                                                |  |                                                                                                                               |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>10-10-1987                                                                                                           |                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY ROSARY                                                                                                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                                              |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>EVANS CHAPEL OF CHIMES YORK ROAD 2325                                                                                                                                                                                                                                            |  |                                                                                                                                   |                                                | 25a. DATE REC'D. BY REGISTRAR<br>OCT 09 1987                                                                                                                |  |                                                                                                                               |                                                 |
|                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |                                                | 25b. REGISTRAR'S SIGNATURE<br>Julia T. [Signature]                                                                                                          |  |                                                                                                                               |                                                 |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "or", item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)



1681 15 2 3 8 20

# RIGHTS



068813 OCT 16-87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                                   |                                                                                            |                                                                                                 |                                                                                                                               |                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edythe Samson</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 08 87</b>                 |                                                                                                                                                             |                                                                                                   | 2b. HOUR<br><b>12:55pM</b>                                                                 |                                                                                                 |                                                                                                                               |                                 |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                                                          |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 8, 1921</b>                                                                                                    |                                                                                                   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>66</b> YRS.                                        |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                        |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                        |                                                                                                 |                                                                                                                               |                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Baltimore Medical Center</b> |                                                                        |                                                                                                                                                             |                                                                                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ENGLISH TEACHER</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>EDUCATION</b>                                                                         |                                 |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             | 13b. COUNTY<br><b>BALTIMORE</b>                                                                   |                                                                                            | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                               |                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>NATHAN BLUMERT</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE HOICHEISER</b>                           |                                                                                            |                                                                                                 |                                                                                                                               |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>NO</b>                                                                                                                                                                                                                                            |  |                                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>232-20-9794</b>                         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS (21209) <b>33</b><br><b>RABBI NORMAN SAMSON 2909 FALLSTAFF RD., APT.</b> |                                                                                            |                                                                                                 |                                                                                                                               |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis, aspiration pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Colonic Obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastatic Colon Carcinoma</b>                                       |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                                   |                                                                                            |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>10-12 days</b><br><b>1 1/2 yrs.</b>                    |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)                                                                                                                                                                                                                     |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                                   |                                                                                            |                                                                                                 |                                                                                                                               |                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                 |  |                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                    |                                                                                            |                                                                                                 |                                                                                                                               |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                             |  |                                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                 |                                                                                            |                                                                                                 |                                                                                                                               |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1987</b> to <b>October 8, 1987</b> , that (I) (we) lost<br>saw the deceased alive on <b>October 8, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                                   |                                                                                            |                                                                                                 |                                                                                                                               |                                 |  |
| 22b. SIGNATURE<br><b>Ruth Kantor</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             | DEGREE<br><b>MD</b>                                                                               |                                                                                            | 22c. DATE SIGNED<br><b>10/8/87</b>                                                              |                                                                                                                               | 22d. ADDRESS<br><b>G.B.M.C.</b> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ruth Kantor, M.D.</b>                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             | 22f. ADDRESS<br><b>G.B.M.C.</b>                                                                   |                                                                                            |                                                                                                 |                                                                                                                               |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(5a) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                      | 23b. DATE<br><b>10/11/87</b>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHAAREI ZION CEM</b>                                     |                                                                                            | 23d. LOCATION<br><b>ROSEDALE BALTIMORE</b> STATE <b>MD</b>                                      |                                                                                                                               |                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO, MD 21215</b>                                                                                                                                                                                                                                    |  |                                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 15 1987</b>                                        |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Gordon-Randall</b>                                                                     |                                 |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP



BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be notified within 72 hours after death with the State Dept. of Health and Mental Hygiene guide to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| Item 1 Film G633 11-10-87 SB                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | STATE OF MARYLAND                                                                                                                                        |  |  |  |  |  |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|
| 1- STATE per funeral home REGISTRAR                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                                                                                                  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | REG. NO.                                                                                                                                                 |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Sister Virginia M. Santiago</b>                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Oct. 4 1987</b>                                                                                                      |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>8:40 P.</b>                                                                                                                                  |  |  |  |  |  |  |  |  |  |
| 4. RACE <b>White</b>                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 4 1898</b>                                                                                                       |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mexico</b>                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS                                                                                                            |  |  |  |  |  |  |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.                                                                                         |  |  |  |  |  |  |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Hospital</b>                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nun</b>                                                                                 |  |  |  |  |  |  |  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <b>Religious</b>                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 13b. CITY OR TOWN <b>Baltimore</b>                                                                                                                       |  |  |  |  |  |  |  |  |  |
| 13c. COUNTY <b>Towson</b>                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Eladio Santiago</b>                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Angela Ortiz</b>                                                                                           |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>218-54-4691</b>                                                                                                              |  |  |  |  |  |  |  |  |  |
| 17. INFORMANT ADDRESS <b>Mission Helpers of the Sacred Heart, 1001 W. Joppa Rd. 21204</b>                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Bilobar Staphylococcal and Klebsiella</b><br>DUE TO, OR AS A CONSEQUENCE OF, (c) <b>Pneumonia</b>                                                       |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>                                                                                               |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Dehydration, Acute Renal Failure</b>                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  |  |  |  |  |  |  |  |  |
| 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                                              |  |  |  |  |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  |  |  |  |  |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/9</b> 19 <b>87</b> , to <b>Oct. 4</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/4</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Patricia A. Savadel</b>                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED <b>10/5/87</b>                                                                                                                          |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Patricia A. Savadel, M.D.</b>                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <b>120 Sr. Pierre Dr., Suite 105, 21204</b>                                                                                                 |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 23b. DATE <b>10/8/87</b>                                                                                                                                 |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Md.</b>                                                                                        |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b> ADDRESS <b>10 W. Padonia Rd.</b>                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 07 1987</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>                                                                |  |  |  |  |  |  |  |  |  |

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1 May 1964  
12 May 1964  
13 May 1964  
14 May 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                   |  |                                                                                                                                       |                                                                 |                                                                                                                                                             |                                                                           |                                                                                  |                                                                                                 |                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Richard E. SAYLOR, Sr.                                                     |  |                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 9, 1987          |                                                                                                                                                             |                                                                           | 2b. HOUR<br>7:14p M                                                              |                                                                                                 |                                                                 |  |
| 3. SEX<br>MAle                                                                                                    |  | 4. RACE<br>White                                                                                                                      |                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 - 14 - 14                                                                                                           |                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS                                        |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                     |                                                                                                 |                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |                                                                 |                                                                                                                                                             |                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Warehouseman |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Exon                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD. |  |                                                                                                                                       | 13b. COUNTY<br>Baltimore                                        |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                            |                                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles J. Saylor                                                       |  |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary R. Murphy |                                                                                                                                                             |                                                                           | 13e. STREET ADDRESS / ZIP CODE<br>4515 Forest View Ave. -21206                   |                                                                                                 |                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                       |  |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR DATES)<br>WWII    |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>Ruth E. Saylor - 4515 Forest View Ave. -21206 |                                                                                  |                                                                                                 |                                                                 |  |

## MEDICAL CERTIFICATION

|                                                                                                                                                                 |  |                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>minutes</u> |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic CVD</u> |  |
|                                                                                                                                                                 |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                       |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Peripheral vascular insufficiency CVD

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                    |  |                                                                                            |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>X</u> |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>X</u> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>X</u>                              |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 13</u> , 19 <u>88</u> , to <u>Oct 9</u> , 19 <u>87</u> , that (we) lost <u>saw</u> the deceased alive on <u>9 Oct</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. |  |                                                                                    |  |                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>John C. Hyle</u>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                    |  | DEGREE<br><u>M.D.</u>                                                                      |  | 22c. DATE SIGNED<br><u>10-11-87</u>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Hyle, M.D.                                                                                                                                                                                                                                                                                                              |  |                                                                                    |  | 22e. ADDRESS<br>7527 Belair Road, Balto., Maryland                                         |  |                                                                                                                            |  |

|                                                                              |  |                       |  |                                                         |  |                                                                   |  |
|------------------------------------------------------------------------------|--|-----------------------|--|---------------------------------------------------------|--|-------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                       |  | 23b. DATE<br>10-12-87 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John C. Miller, Inc. -6415 Belair Road 21206 |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 13 1987            |  | 25b. REGISTRAR'S SIGNATURE<br><u>John C. Miller</u>               |  |

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*[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
IDYLLETTE B. SCHELBERG

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
10-8-87 3:00 A.M.

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
08 15 1891

6. AGE (IN YEARS LAST BIRTHDAY)

76 YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Mississippi

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Balto. County MD.

10. CITY OR TOWN OF DEATH

Balto.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

St. Joseph's Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Teacher

12b. KIND OF BUSINESS OR INDUSTRY

College

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

V

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

4 E. 32nd St.

21218

14. FATHER'S NAME

FIRST MIDDLE LAST  
Junius M. Batte

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Evelyn Fitzgerald

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

215 22 2759

17. INFORMANT

ADDRESS

Mr. Charles L. Schelberg, Jr. Annapolis, Md. 21401

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b) PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4 DAYS

4 DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NO! WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (this hospital) attended the deceased from 10-7-87 19 to 10-8-87 19, that (we) last  
saw the deceased alive on 10-7-87 19, and that in (my) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Francis T. Khoo

DEGREE

MD

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☒

22c. DATE SIGNED

10-8-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

FRANCIS T. KHOO

22e. ADDRESS

St. Joseph Hospital

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

10/8/87

23c. NAME OF CEMETERY OR CREMATORY

Old Wye Church

23d. LOCATION

CITY OR TOWN

Wye Mills, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

MITCHELL-WIEDEFELD HOME, INC.

ADDRESS

6500 York Rd.

25a. DATE REC'D. BY REGISTRAR

OCT 14 1987

25b. REGISTRAR'S SIGNATURE

Dorothy R. Rader

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 28267  
REG. NO.

|                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  |                                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                               |                                                                                                 |                                                                                                                               |                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lucetta Fanchon Schildwachter                                                                                                                                                                                                                                                                                    |  |                                                                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 5, 1987                                                                                               |                                                                                                                                                             |                                                                                | 2b. HOUR<br>M                                                                 |                                                                                                 |                                                                                                                               |                                                             |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>Caucasian                                                                                                             |                                                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 01 16                                                                                                               |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS                                     |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                     |                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                    |                                                                                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |                                                                                                 |                                                                                                                               |                                                             |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>9014 Old Court Road |                                                                                                                                                      |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland                                                                                                                                                                                                                                  |  |                                                                                                                                  | 13b. COUNTY<br>Baltimore                                                                                                                             |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                 |                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                               | 13e. STREET ADDRESS / ZIP CODE<br>9014 Old Court Road 21207 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Anthony Bayer                                                                                                                                                                                                                                                                                         |  |                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida Mae Reiblich                                                                                    |                                                                                                                                                             |                                                                                |                                                                               |                                                                                                 |                                                                                                                               |                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                              |  |                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----                                                                                     |                                                                                                                                                             | 17. INFORMANT Mrs. Hollis Baltimore<br>105 Waldron Ave. Pikesville, MD. 21208  |                                                                               |                                                                                                 |                                                                                                                               |                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hepatic Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Acute Metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>Breast Cancer</u>                                                                |  |                                                                                                                                  |                                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                               |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 wks</u><br><u>8 mo</u><br><u>3 1/2 yrs</u>                            |                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                      |  |                                                                                                                                  |                                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                               |                                                                                                 |                                                                                                                               |                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                |  |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |                                                                               |                                                                                                 |                                                                                                                               |                                                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                               |  |                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                               |                                                                                                 |                                                                                                                               |                                                             |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>6/80</u> 19 <u>84</u> to <u>10/5</u> 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>9/24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |                                                                                                                                  |                                                                                                                                                      |                                                                                                                                                             |                                                                                |                                                                               |                                                                                                 |                                                                                                                               |                                                             |  |
| 22b. SIGNATURE<br><u>William C. Waterfield MD</u>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                                                             |                                                                                | 22c. DATE SIGNED<br><u>10/6/87</u>                                            |                                                                                                 |                                                                                                                               |                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>William C. Waterfield</u>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                  | 22e. ADDRESS<br><u>St Agnes Hospital</u><br><u>900 Caton Ave Balb Md 21229</u>                                                                       |                                                                                                                                                             |                                                                                |                                                                               |                                                                                                 |                                                                                                                               |                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>10/8/87                                                                                                             |                                                                                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Olive U.M. Cem                                                                                                  |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown Baltimore MD.      |                                                                                                 |                                                                                                                               |                                                             |  |
| 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc.<br>NAME ADDRESS<br>8728 Liberty Road Randallstown, MD. 21133                                                                                                                                                                                                                                  |  |                                                                                                                                  |                                                                                                                                                      |                                                                                                                                                             | 25a. DATE REC'D BY REGISTRAR<br>OCT 06 1987                                    |                                                                               | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson-Randall</u>                                           |                                                                                                                               |                                                             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please use the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, a medical examiner must be notified at once.

OFFICE OF THE SECRETARY

OF THE ARMY

WASHINGTON, D. C.

JAN 10 1961

MEMORANDUM FOR THE SECRETARY

SUBJECT: [Illegible]

[Illegible]

[Illegible]

[Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                       |  |                                                                     |                                                                                                                                     |                                                                                                                                            | REG. NO.                                                                               |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                     |  |                                                                     | DECEASED NAME (TYPE OR PRINT)<br>SARAH A. SCHISLER                                                                                  |                                                                                                                                            | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 20, 1987                                   |                                                                                                                            |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                           |  |                                                                     | 4. RACE<br>WHITE                                                                                                                    |                                                                                                                                            | 5. DATE OF BIRTH MONTH DAY YEAR<br>OCT. 31, 1919                                       |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WEST VA.                                                                                                                                                                                                                                                                      |  |                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                              |                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.                                             |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>PERRY HALL                                                                                                                                                                                                                                                                                    |  |                                                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1 DUNHARVEY PLACE APT. 1A |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                           |                                                                                                                            |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                     |  |                                                                     | 13b. COUNTY<br>BALTIMORE                                                                                                            |                                                                                                                                            | 13c. CITY OR TOWN<br>PERRY HALL                                                        |                                                                                                                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ALBERTO REYNOLDS                                                                                                                                                                                                                                                                    |  |                                                                     | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>STELLA POWELL                                                                         |                                                                                                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PRESS OPER. STEEL CO. |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                    |  |                                                                     | 16b. SOCIAL SECURITY NO.<br>235 203118                                                                                              |                                                                                                                                            | 17. INFORMANT ADDRESS<br>FAMILY RECORDS                                                |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Ovarian carcinomatosis                                                                   |  |                                                                     |                                                                                                                                     |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>~18 months.                            |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.                                                                                                                                                                                           |  |                                                                     |                                                                                                                                     |                                                                                                                                            |                                                                                        |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.<br>19             |                                                                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                        |                                                                                                                            |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                     | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                             |                                                                                        |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1986 to October 20, 1987, that (I) (we) last saw the deceased alive on October 19, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                     |                                                                                                                                     |                                                                                                                                            |                                                                                        |                                                                                                                            |
| 22b. SIGNATURE<br>Paul Chang, MD                                                                                                                                                                                                                                                                                           |  | DEGREE                                                              |                                                                                                                                     | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                        | 22c. DATE SIGNED<br>OCT-21-1987                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. PAUL CHANG                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS<br>GOOD SAMARITAN HOSPITAL                             |                                                                                                                                     |                                                                                                                                            |                                                                                        |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>10-23-1987                                             |                                                                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT                                                                                          |                                                                                        | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                                              |
| 24. FUNERAL DIRECTOR NAME<br>EVANS CHAPEL OF MEMORIES ROAD                                                                                                                                                                                                                                                                 |  | ADDRESS<br>8800 HARBOR                                              |                                                                                                                                     | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1987                                                                                               |                                                                                        |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                            |  |                                                                     |                                                                                                                                     | 25b. REGISTRAR'S SIGNATURE<br>Julia Hudson-Budack                                                                                          |                                                                                        |                                                                                                                            |

BP

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RECEIVED  
JAN 23 1964

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|                                                                                                                                                          |  |                                                             |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|--------------------------------------|--|----------------------------------------------|--|--------------------------|--|----------|--|---------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                      |  | FIRST JOHN                                                  |  | MIDDLE Conrad                                                                 |  | LAST Schmick                                                        |  | 2a. DATE KNOWN OF DEATH              |  | MONTH 10                                     |  | DAY 17                   |  | YEAR 87  |  | 2b. HOUR 8:00 |  |
| 3. SEX                                                                                                                                                   |  | 4. RACE                                                     |  | 5. DATE OF BIRTH                                                              |  | 6. AGE (IN YEARS)                                                   |  | IF UNDER 1 YR.                       |  | IF UNDER 24 HRS.                             |  | 7c. DATE PRONOUNCED DEAD |  | MONTH 10 |  | DAY 17        |  |
| Male                                                                                                                                                     |  | White                                                       |  | Feb. 24, 1912                                                                 |  | 75 YRS.                                                             |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED                                                                    |  | NEVER MARRIED                                                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                              |  |                          |  |          |  |               |  |
| Maryland                                                                                                                                                 |  | U.S.A.                                                      |  | WIDOWED                                                                       |  | DIVORCED                                                            |  | Baltimore County                     |  | MD.                                          |  |                          |  |          |  |               |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| Timonium                                                                                                                                                 |  | 2 Castle Hill Ct. 21093                                     |  | Vice President-Gen. Ship Repair                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| 13a. STATE                                                                                                                                               |  | 13b. COUNTY                                                 |  | 13c. CITY OR TOWN                                                             |  | 13d. INSIDE CITY LIMITS?                                            |  | 13e. STREET ADDRESS                  |  |                                              |  |                          |  |          |  |               |  |
| Maryland                                                                                                                                                 |  | Baltimore                                                   |  | Timonium                                                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 2 Castle Hill Ct. 21093              |  |                                              |  |                          |  |          |  |               |  |
| 14. FATHER'S NAME                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                    |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| FIRST Conrad                                                                                                                                             |  | MIDDLE                                                      |  | LAST Schmick                                                                  |  | FIRST Katherine                                                     |  | MIDDLE                               |  | LAST Fuchs                                   |  |                          |  |          |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                             |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT                                                                 |  | ADDRESS                                                             |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| No                                                                                                                                                       |  | 216-09-0064                                                 |  | Rebekah A. Schmick - same as #13e                                             |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| PART I DEATH WAS CAUSED BY:                                                                                                                              |  | A SEVERE                                                    |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| IMMEDIATE CAUSE (a):                                                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                              |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                            |  | (b):                                                        |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
|                                                                                                                                                          |  | DUE TO, OR AS A CONSEQUENCE OF                              |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
|                                                                                                                                                          |  | (c):                                                        |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                      |  |                                                             |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| 19a. DATE OF OPERATION                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?                                                                  |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
|                                                                                                                                                          |  |                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |  | 21b. TIME OF INJURY                                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
|                                                                                                                                                          |  | HOUR A.M. MONTH DAY YEAR                                    |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
|                                                                                                                                                          |  | P.M. 19                                                     |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION                                                                 |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
|                                                                                                                                                          |  |                                                             |  | STREET CITY OR TOWN COUNTY STATE                                              |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| 22a. I certify that I took charge of the remains described above, held on                                                                                |  | Autopsy <input type="checkbox"/>                            |  | Inspection <input checked="" type="checkbox"/>                                |  | Inquiry <input type="checkbox"/>                                    |  | and in my opinion                    |  |                                              |  |                          |  |          |  |               |  |
| death resulted from:                                                                                                                                     |  | Natural causes <input checked="" type="checkbox"/>          |  | Accident <input type="checkbox"/>                                             |  | Suicide <input type="checkbox"/>                                    |  | Homicide <input type="checkbox"/>    |  | Undetermined manner <input type="checkbox"/> |  |                          |  |          |  |               |  |
| ACTUAL SIGNATURE                                                                                                                                         |  | TITLE (SPECIFY)                                             |  | M.D.                                                                          |  | MEDICAL EXAMINER                                                    |  | DATE SIGNED                          |  |                                              |  |                          |  |          |  |               |  |
| Stanley Z. Felsenberg MD.                                                                                                                                |  | Deputy                                                      |  |                                                                               |  |                                                                     |  | 10/12/87                             |  |                                              |  |                          |  |          |  |               |  |
| EXAMINER'S NAME (TYPE OR PRINT)                                                                                                                          |  | ADDRESS                                                     |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| Stanley Z. Felsenberg MD.                                                                                                                                |  | 11 E. Chase 21202                                           |  |                                                                               |  |                                                                     |  |                                      |  |                                              |  |                          |  |          |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL                                                                                                                          |  | 23b. DATE                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY                                            |  | 23d. LOCATION                                                       |  | COUNTY                               |  | STATE                                        |  |                          |  |          |  |               |  |
| Burial                                                                                                                                                   |  | 10-20-87                                                    |  | Dulaney Valley                                                                |  | Timonium,                                                           |  | Balto.,                              |  | Md.                                          |  |                          |  |          |  |               |  |
| 24. FUNERAL DIRECTOR                                                                                                                                     |  | NAME                                                        |  | ADDRESS                                                                       |  | 25a. DATE REC'D BY REGISTRAR                                        |  | 25b. REGISTRAR'S SIGNATURE           |  |                                              |  |                          |  |          |  |               |  |
| Ruck Towson Funeral Home, Inc.,                                                                                                                          |  | 1050 York Rd.                                               |  | Towson, Md. 21204                                                             |  | OCT 21 1987                                                         |  |                                      |  |                                              |  |                          |  |          |  |               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                    |                                                                                                                                                          |                                                                                              |                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MILTON E. SCHRUFER</b>                                                                                                                                                                                                                                                                                            |                                                                                                                                    |                                                                                                                                                          | 2a. DATE OF DEATH MONTH DAY YEAR <b>10 15 87</b> 2b. HOUR <b>927</b> AM                      |                                                                        |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                       | 4. RACE <b>WHITE</b>                                                                                                               | 5. DATE OF BIRTH MONTH DAY YEAR <b>OCT 31 1905</b>                                                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS                                                | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>                             |                                                                        |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>                                                                                                                                                                                                                                                                                                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS HOSPICE</b> |                                                                                                                                                          | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF EMP</b>                | 12b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>                        |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>                                                                                                                                                                                                                                  | 13b. COUNTY <b>BALTIMORE</b>                                                                                                       | 13c. CITY OR TOWN <b>SPARKS</b>                                                                                                                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <b>Box 525 21152 14919 YORK ROAD</b>    |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE SCHRUFER</b>                                                                                                                                                                                                                                                                                               |                                                                                                                                    | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY BERGAN</b>                                                                                            |                                                                                              |                                                                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                              |                                                                                                                                    | 16b. SOCIAL SECURITY NO. <b>217 364228</b>                                                                                                               |                                                                                              | 17. INFORMANT ADDRESS <b>Family Records</b>                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC PROSTATE CANCER</b>                                                                                                                                                                                              |                                                                                                                                    |                                                                                                                                                          |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____                                                                                                                                                                                                                                                                                                                 |                                                                                                                                    |                                                                                                                                                          |                                                                                              |                                                                        |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                                                |                                                                                                                                    |                                                                                                                                                          |                                                                                              |                                                                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>PATHOLOGICAL FRACTURE RIGHT FEMUR</b>                                                                                                                                                                                |                                                                                                                                    |                                                                                                                                                          |                                                                                              |                                                                        |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                  |                                                                                                                                    |                                                                                                                                                          |                                                                                              |                                                                        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                       | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |                                                                                              |                                                                        |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                              |                                                                        |
| 22a. I certify that (I) this hospital attended the deceased from <b>10-9</b> 19 <b>87</b> to <b>10-15</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10-15</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |                                                                                                                                    |                                                                                                                                                          |                                                                                              |                                                                        |
| 22b. SIGNATURE <b>Carla S. Alexander</b>                                                                                                                                                                                                                                                                                                                 |                                                                                                                                    | DEGREE <b>M.D.</b>                                                                                                                                       |                                                                                              | 22c. DATE SIGNED <b>10-15-87</b>                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carla S. Alexander, M.D.</b>                                                                                                                                                                                                                                                                                    |                                                                                                                                    | 22e. ADDRESS <b>Stella Maris Hospice Dulaney Valley Rd. - Towson, MD 21204</b>                                                                           |                                                                                              |                                                                        |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                  | 23b. DATE <b>10-17-1987</b>                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY <b>HEREFORD BAPTIST</b>                                                                                               | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>HEREFORD BALTO. MD.</b>                           |                                                                        |
| 24. FUNERAL DIRECTOR NAME <b>EVANS CHAPEL OF CHIMES</b> ADDRESS <b>2325 YORK RO.</b>                                                                                                                                                                                                                                                                     |                                                                                                                                    | 25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1987</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Anderson-Randall</b>                                                |                                                                                              |                                                                        |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28241

|                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                          |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOROTHY V. SCHURMAN</b>                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 19, 1987</b>                                  |                                                                                          | 2b. HOUR<br>MIN.<br><b>10:30A</b>                                                                                          |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                          | 4. RACE<br><b>White</b>                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YR.<br><b>2 8 12</b>                                                                                                          |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b>                                             | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Florida</b>                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                      |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |                                                                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                                                                              |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                          |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                          |                                                                                                                            |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                    | 13b. COUNTY<br><b>-</b>                                                                                                                 | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>404 N. Linwood Avenue 21224</b>                                |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lorenzo Albert Gough</b>                                                                                                                                                                                                                                                                            |                                                                                                                                         |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Ann Pafel</b>                     |                                                                                          |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                   |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-07-8556D</b>                                                                              |                                                                                                 | 17. INFORMANT<br><b>Virginia J. Schurman, 404 N. Linwood Avenue Baltimore, Md. 21224</b> |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recurrent Breast Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary Emboli</b>                                                  |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b><br><b>1 year</b><br><b>2 mon.</b>                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                              |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                          |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                           |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                         |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                          |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                     |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                          |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 22, 1987</b> to <b>Oct 19, 1987</b> , that (I) (we) last saw the deceased alive on <b>October 17, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                                                                                                                         |                                                                                                                                                             |                                                                                                 |                                                                                          |                                                                                                                            |
| 22b. SIGNATURE<br><b>Charles Padgett</b> DEGREE <b>MD</b>                                                                                                                                                                                                                                                                                        |                                                                                                                                         |                                                                                                                                                             |                                                                                                 | 22c. DATE SIGNED<br><b>10/20/87</b>                                                      |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles Padgett</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                         |                                                                                                                                                             | 22e. ADDRESS<br><b>5601 Loch Raven Blvd. Baltimore, Md 21239</b>                                |                                                                                          |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                       | 23b. DATE<br><b>10-22-87</b>                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>                                                                                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Md.</b>             |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br><b>Ann S. Matthews, Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224</b>                                                                                                                                                                                                                                    |                                                                                                                                         |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1987</b>                                             |                                                                                          |                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                         |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rudolph</b>                                     |                                                                                          |                                                                                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, sign and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                          |                                                                |                                                                                      |                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Emmy SCHWAB</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 24, 1987</b> |                                                                                      | 2b. HOUR<br><b>8:55 PM</b> |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>White</b>                                                                                                                                  |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 12, 1904</b>                            |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                            |                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b><br>YRS MONTHS DAYS                      |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b>             |                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |                            |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                          |                                                                | 13c. CITY OR TOWN<br><b>Elmwood</b>                                                  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Degenhart</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josepha Remmale</b>                                                                                  |                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home maker</b>                               |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>371-42-5708</b>                                                                                                           |                                                                | 17. INFORMANT<br>ADDRESS<br><b>Baltimore, MD.</b>                                    |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Probable Myocardial Infarction</b>                                                                          |  |                                                                                                                                                          |                                                                |                                                                                      |                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                            |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |                                                                |                                                                                      |                            |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |                                                                |                                                                                      |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC.)                                                                                     |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                            |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 20</b> , 19 <b>87</b> , to <b>October 24</b> , 19 <b>87</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>October 24</b> , 19 <b>87</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |                                                                                                                                                          |                                                                |                                                                                      |                            |  |
| 22b. SIGNATURE<br><b>Liao</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | DEGREE<br><b>MD</b>                                                                                                                                      |                                                                | 22c. DATE SIGNED<br><b>10/24/87</b>                                                  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. Liao MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>                                                                                                  |                                                                |                                                                                      |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>Oct 27, 1987</b>                                                                                                                         |                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem</b>                    |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>DIPPEL FUNERAL HOME, INC.</b><br><b>7110 BELAIR ROAD BALTIMORE, MARYLAND 21206</b>                            |                                                                |                                                                                      |                            |  |
| 25a. DATE REC'D BY REGISTRAR (SEE REGISTRAR'S SIGNATURE)<br><b>OCT 26 1987</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                          |                                                                |                                                                                      |                            |  |

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068030 OCT 08 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by a certifying physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the funeral home. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 28215

|                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                              |  | 2a. DATE OF DEATH                                                                                      |  | MONTH DAY YEAR                                                                                                                                           |  | 2b. HOUR                                                            |                                              |
| DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                       |  | FIRST MIDDLE LAST                                                                                      |  | 10 5 87                                                                                                                                                  |  | 9:58 A.M.                                                           |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                                              |
| Male                                                                                                                                                                                                                                                                                                                                                                                |  | White                                                                                                  |  | 9 14 1914                                                                                                                                                |  | 73 YRS                                                              |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                              |
| ENGLAND                                                                                                                                                                                                                                                                                                                                                                             |  | USA                                                                                                    |  |                                                                                                                                                          |  | BALTIMORE COUNTY MD                                                 |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                              |
| TOWSON                                                                                                                                                                                                                                                                                                                                                                              |  | 8415 BELLONA LN. 21204                                                                                 |  | RABBI                                                                                                                                                    |  | N/A.                                                                |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |                                              |
| MARYLAND BALT.                                                                                                                                                                                                                                                                                                                                                                      |  | TOWSON                                                                                                 |  |                                                                                                                                                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME                                                                               |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)                                                                                         |  | 16b. SOCIAL SECURITY NO.                                            |                                              |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                   |  | FIRST MIDDLE LAST                                                                                      |  | No                                                                                                                                                       |  | 564-50-2314                                                         |                                              |
| MARTIN                                                                                                                                                                                                                                                                                                                                                                              |  | SCHWARTZ                                                                                               |  | 17. INFORMANT                                                                                                                                            |  | ADDRESS                                                             |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                     |  | GIZELLA CITRON                                                                                         |  | Rabbi R. Schwartz                                                                                                                                        |  | 21215                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | 6101 PARK HEIGHTS                                                                                                                                        |  |                                                                     |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>                                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic renal cell carcinoma</u>                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                                                                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| End Stage Renal Disease                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                           |  |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                     |  | P.M. 19                                                                                                |  |                                                                                                                                                          |  |                                                                     |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December 24</u> , 19 <u>86</u> , to <u>October 5</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>October 3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                      |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED                                                    |                                              |
| <u>Jeffrey N. Posner, M.D.</u>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                        |  |                                                                                                                                                          |  | October 5, 1987                                                     |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                               |  | 22e. ADDRESS                                                                                           |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                |  |                                                                     |                                              |
| Jeffrey N. Posner, M.D.                                                                                                                                                                                                                                                                                                                                                             |  | 1818 Pot Spring Rd. #102 Lutherville, M.D.                                                             |  | Burial                                                                                                                                                   |  |                                                                     |                                              |
| 23b. DATE                                                                                                                                                                                                                                                                                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATOR                                                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                                                                                                  |  |                                                                     |                                              |
| 10/7/87                                                                                                                                                                                                                                                                                                                                                                             |  | Judea Hills                                                                                            |  | Jerusalem Israel                                                                                                                                         |  |                                                                     |                                              |
| 24. FUNERAL DIRECTOR NAME                                                                                                                                                                                                                                                                                                                                                           |  | ADDRESS                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                          |                                              |
| HEBREW MEMORIAL FH - 1100 REISTERSTOWN Rd                                                                                                                                                                                                                                                                                                                                           |  | 21208                                                                                                  |  | OCT 05 1987                                                                                                                                              |  |                                                                     |                                              |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 7 2 8 2 7 4

|                                                                                                                                                                                                                                                                                                                                                                    |  |                         |                                                                                                                                                 |                                                       |  |                                                                                                                                                              |  |                                   |                                                                                                                            |                                              |  |                                                                            |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|----------------------------------------------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SELWYN ARNOLD SCHWARTZ</b>                                                                                                                                                                                                                                                                                               |  |                         | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-2-87</b>                                                                                           |                                                       |  | 2b. HOUR<br><b>9:15</b><br>M                                                                                                                                 |  |                                   |                                                                                                                            |                                              |  |                                                                            |  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>White</b> |                                                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 19 26</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b><br>YRS                                                                                                          |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS |                                                                                                                            | 8. IF UNDER 1 YEAR<br>HOURS MIN              |  |                                                                            |  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                    |  |                         | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                      |                                                       |  | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                   | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b><br>MD.                                                    |                                              |  |                                                                            |  |  |
| 13. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                   |  |                         | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore Co. General Hosp.</b> |                                                       |  | 15. 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MEAT CUTTER</b>                                                                   |  |                                   | 16. 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD</b>                                                                       |                                              |  |                                                                            |  |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                       |  |                         | 13b. COUNTY<br><b>Balt.</b>                                                                                                                     |                                                       |  | 13c. CITY OR TOWN<br><b>Woodlawn</b>                                                                                                                         |  |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                              |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7 Castleford Ct. 21207</b>            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                           |  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                                                                 |                                                       |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                           |  |                                   | 16b. SOCIAL SECURITY NO.<br><b>195-18-2132</b>                                                                             |                                              |  | 17. INFORMANT<br>ADDRESS<br><b>Rebecca Schwartz 7 Castleford Ct. 21207</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |                                                                                                                                                 |                                                       |  |                                                                                                                                                              |  |                                   |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>CELLULITIS OF LEG, DIABETIS MELLITUS, PERIPHERAL VASCULAR DISEASE, CORONARY ARTERY DISEASE, HYPERTENSION, CONGESTIVE HEART FAILURE</b>                                                                                      |  |                         |                                                                                                                                                 |                                                       |  |                                                                                                                                                              |  |                                   |                                                                                                                            |                                              |  |                                                                            |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                |                                                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                    |  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |  |                                                                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                               |                                                       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                               |  |                                   |                                                                                                                            |                                              |  |                                                                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                          |                                                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                            |  |                                   |                                                                                                                            |                                              |  |                                                                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-21</b> , 19 <b>87</b> , to <b>10-2</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10-2</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                         |                                                                                                                                                 |                                                       |  |                                                                                                                                                              |  |                                   |                                                                                                                            |                                              |  |                                                                            |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                               |  |                         | DEGREE                                                                                                                                          |                                                       |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                   |  |                                   | 22c. DATE SIGNED<br><b>10-2-87</b>                                                                                         |                                              |  |                                                                            |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICARDO B. CONTRERAS MD.</b>                                                                                                                                                                                                                                                                                           |  |                         | 22e. ADDRESS<br><b>BC6H - RANDALLSTOWN MD. 21133</b>                                                                                            |                                                       |  |                                                                                                                                                              |  |                                   |                                                                                                                            |                                              |  |                                                                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                         |  |                         | 23b. DATE<br><b>10/6/87</b>                                                                                                                     |                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. Veterans Cem.</b>                                                                                               |  |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Garrison Forest Balt MD</b>                                               |                                              |  |                                                                            |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HEBREW MEMORIAL F.H.</b>                                                                                                                                                                                                                                                                                                        |  |                         | ADDRESS<br><b>1100 REISTERSTOWN RD.</b>                                                                                                         |                                                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 05 1987</b>                                                                                                          |  |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |                                              |  |                                                                            |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                        |                                                               |                                                                                                                                                             |                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Barbara - SEASE</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 4, 1987</b> |                                                                                                                                                             | 2b. HOUR<br><b>6:15a.m.</b> |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>White</b>                                                                                                                                                                                                                                |                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 19, 1900</b>                                                                                               |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS                                                                                                                                                                                                                                                                                                        |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                                                                                                                                     |                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                             |                                                               | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                                                                                         |                             |  |
| 12. CITY OR TOWN OF DEATH<br><b>Rossville</b>                                                                                                                                                                                                                                                                                                           |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b>                                                                                                           |                                                               | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Hecht Company</b>                                                                |                             |  |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                 |  | 15b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                        |                                                               | 15c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                             |  |
| 16. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                          |  | 17. STREET ADDRESS / ZIP CODE<br><b>5403 Mayview Avenue 21206</b>                                                                                                                                                                                      |                                                               | 18. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Berdie -</b>                                                                                            |                             |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmer Bernhard</b>                                                                                                                                                                                                                                                                                         |  | 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>                                                                                                                                                                       |                                                               | 21. SOCIAL SECURITY NO.<br><b>217-34-6492</b>                                                                                                               |                             |  |
| 22. INFORMANT<br>ADDRESS<br><b>Mr. Howard T. Sease Same</b>                                                                                                                                                                                                                                                                                             |  | 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                                                             |                             |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                        |                                                               |                                                                                                                                                             |                             |  |
| 24. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                   |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                        |                                                               | 26. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |                             |  |
| 27. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                  |  | 28. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                                                                                                                       |                                                               | 29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                               |                             |  |
| 30. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                             |  | 31. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                  |                                                               | 32. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                            |                             |  |
| 33. I certify that (x) (this hospital) attended the deceased from <b>September 27, 1987</b> , to <b>October 4, 1987</b> , that (x) (we) last saw the deceased alive on <b>October 4, 1987</b> , and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (did not) view the body after death. |  |                                                                                                                                                                                                                                                        |                                                               |                                                                                                                                                             |                             |  |
| 34. SIGNATURE<br><i>Michael A. Fulop</i>                                                                                                                                                                                                                                                                                                                |  | 35. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                                                                                               |                                                               | 36. DATE SIGNED<br><b>10-4-87</b>                                                                                                                           |                             |  |
| 37. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Fulop, M.D.</b>                                                                                                                                                                                                                                                                                      |  | 38. ADDRESS<br><b>9000 Franklin Square Dr. 21237</b>                                                                                                                                                                                                   |                                                               |                                                                                                                                                             |                             |  |
| 39. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                            |  | 40. DATE<br><b>Oct. 6, 1987</b>                                                                                                                                                                                                                        |                                                               | 41. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                                                                                                        |                             |  |
| 42. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>                                                                                                                                                                                                                                                                         |  | 43. ADDRESS                                                                                                                                                                                                                                            |                                                               | 44. DATE REC'D. BY REGISTRAR<br><b>OCT 05 1987</b>                                                                                                          |                             |  |
| 45. REGISTRAR'S SIGNATURE<br><i>Julia Darden-Rudner</i>                                                                                                                                                                                                                                                                                                 |  | 46. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                              |                                                               |                                                                                                                                                             |                             |  |

MEDICAL CERTIFICATION

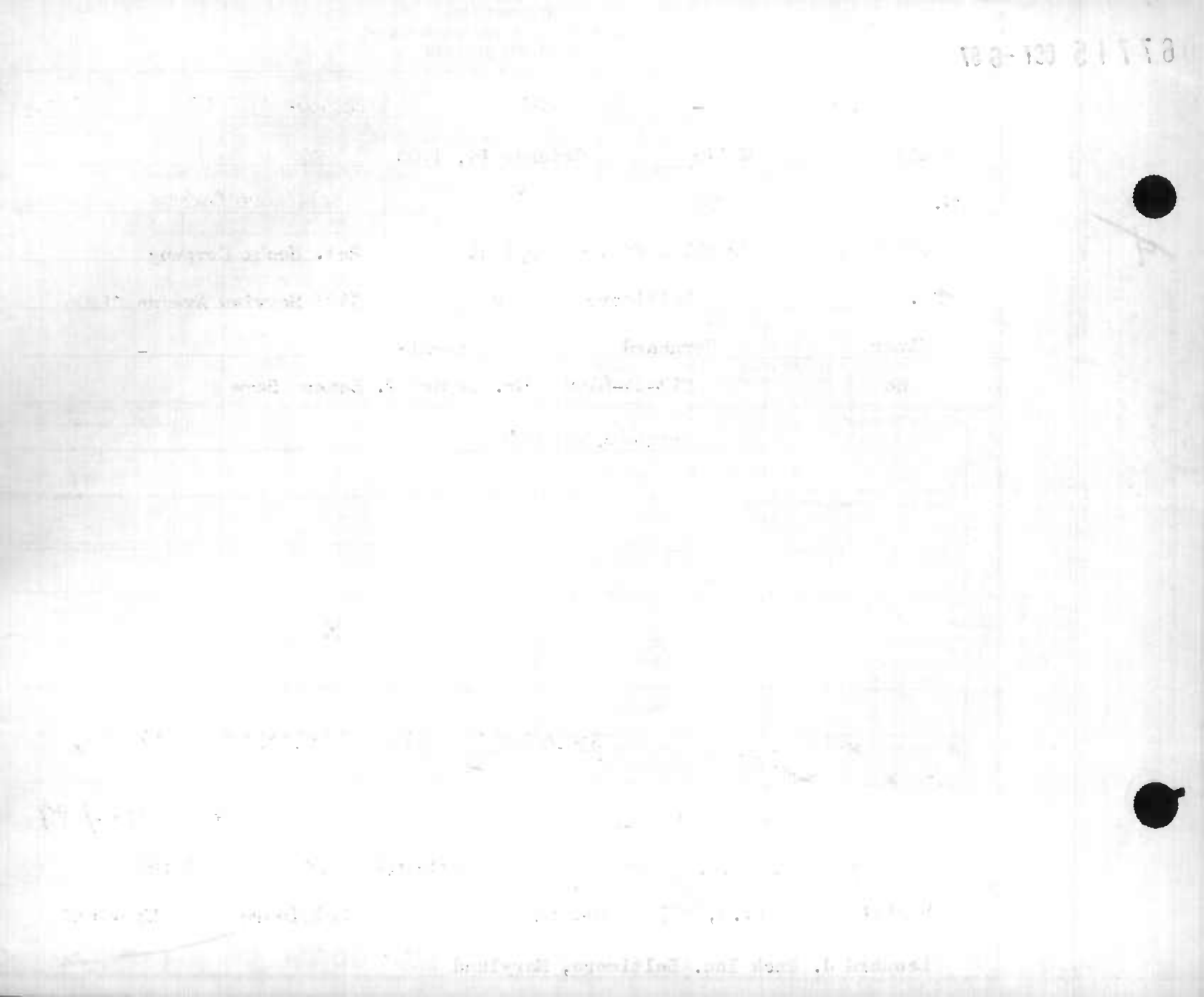
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                              |  |                                                                                                                                       |                                                         |                                                                                                                                                             | REG. NO.                                                                             |                                                                      |                                                                                                                            |                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edith Viola SEIFERT                                                                                                                                                                                                                                                                        |  |                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 16, 1987 |                                                                                                                                                             | 2b. HOUR<br>1:08p M                                                                  |                                                                      |                                                                                                                            |                              |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>White                                                                                                                      |                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 13, 1921                                                                                                          |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66<br>YRS. MONTHS DAYS HOURS MIN. |                                                                                                                            |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.         |                                                                                                                            |                              |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |                                                         |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker        |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>-                                                                                     |                              |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       | 13b. COUNTY<br>Baltimore                                |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                       |                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                              |  |
| 13e. STREET ADDRESS, ZIP CODE<br>4439 Kendi Rd. 21236                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |                                                         |                                                                                                                                                             |                                                                                      |                                                                      |                                                                                                                            |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jerry Charles Hladik                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                                                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nettie Viola Langkam                                                                                       |                                                                                      |                                                                      |                                                                                                                            |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-22-2184                                                                |                                                         | 17. INFORMANT ADDRESS<br>Shirley H. Leasure (sister) 9007 Lodi Rd. 21236                                                                                    |                                                                                      |                                                                      |                                                                                                                            |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Left thrombotic cerebral vascular accident<br>DUE TO, OR AS A CONSEQUENCE OF (c) Anterior, inferolateral myocardial ischemia         |  |                                                                                                                                       |                                                         |                                                                                                                                                             |                                                                                      |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Congestive heart failure, hypertension, diabetes mellitus                                                                                                                                        |  |                                                                                                                                       |                                                         |                                                                                                                                                             |                                                                                      |                                                                      |                                                                                                                            |                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                      |                                                         |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                                      |                                                                      |                                                                                                                            |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                      |                                                                                                                            |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from October 12, 1987, to October 16, 1987, that (I) (we) last saw the deceased alive on October 16, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                       |                                                         |                                                                                                                                                             |                                                                                      |                                                                      |                                                                                                                            |                              |  |
| 22b. SIGNATURE<br>BACHOWSKI                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |                                                         | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                      |                                                                      |                                                                                                                            | 22c. DATE SIGNED<br>10/16/87 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BACHOWSKI                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |                                                         | 22e. ADDRESS<br>9000 Franklin Square Dr., Balto., 21237                                                                                                     |                                                                                      |                                                                      |                                                                                                                            |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>10/20/87                                                                                                                 |                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD                                                                                                              |                                                                                      | 23d. LOCATION<br>BALTIMORE COUNTY MD. STATE                          |                                                                                                                            |                              |  |
| 24. FUNERAL HOME<br>NAME SCHMIDTKE FUNERAL HOME, INC.<br>ADDRESS 9705 BELAIR RD., BALTO. MD. 21236                                                                                                                                                                                                                                |  |                                                                                                                                       |                                                         | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1987                                                                                                                |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                 |                                                                                                                            |                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |                                                                   |                                                                                                                                                              |                                                            |                                                                                |                                                               |                                                                                                                         |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            |                                                                   | REG. NO.                                                                                                                                                     |                                                            |                                                                                |                                                               |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Charles EDWIN Sheats                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                            |                                                                   | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 30 87                                                                                                                 |                                                            |                                                                                |                                                               | 2b. HOUR<br>11:30am                                                                                                     |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                                                                           |                                                                   | 5. DATE OF BIRTH MONTH DAY YEAR<br>July 7, 1910                                                                                                              |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS                                      |                                                               | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                                                           |                                              |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                      |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                      |                                                                   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |                                                               |                                                                                                                         |                                              |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center |                                                                   |                                                                                                                                                              |                                                            | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Realtor       |                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Real Estate                                                                        |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Phoenix                                                                                                                                                                                                                                                                       |  |                                                                                                                                            |                                                                   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                            | 13e. STREET ADDRESS / ZIP CODE<br>3600 Blenheim Road 21131                     |                                                               |                                                                                                                         |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Edwin Jarman Sheats                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                            |                                                                   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Sarah Louise Randall                                                                                           |                                                            |                                                                                |                                                               |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                            |                                                                   | 16b. SOCIAL SECURITY NO.<br>218 28 1330                                                                                                                      |                                                            | 17. INFORMANT ADDRESS<br>Mrs. Anna Margaret Sheats 3600 Blenheim Road          |                                                               |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Acute Pulmonary Edema</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |                                                                                                                                            |                                                                   |                                                                                                                                                              |                                                            |                                                                                |                                                               |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |                                                                                                                                                              |                                                            | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |                                                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19           |                                                                                                                                                              |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                               |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                            | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                              |                                                            | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |                                                               |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 30, 1987</u> to <u>October 30, 1987</u> , that (I) (we) last saw the deceased alive on <u>October 30, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                   |  |                                                                                                                                            |                                                                   |                                                                                                                                                              |                                                            |                                                                                |                                                               |                                                                                                                         |                                              |
| 22b. SIGNATURE<br>Phillip N. Phillips, M.D.                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            |                                                                   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>         |                                                            |                                                                                |                                                               | 22c. DATE SIGNED<br>10/30/87                                                                                            |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Phillip N. Phillips, M.D.                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                            |                                                                   | 22e. ADDRESS<br>G.B.M.C.                                                                                                                                     |                                                            |                                                                                |                                                               |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                            | 23b. DATE<br>2 NOV 87                                             |                                                                                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Ceme. |                                                                                | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Timonium, Maryland |                                                                                                                         |                                              |
| 24. FUNERAL HOME<br>J. E. Lowell Lemmon Padonia & York Rds.                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                            |                                                                   |                                                                                                                                                              |                                                            | 25a. DATE REC'D. BY REGISTRAR<br>NOV 2 1987                                    |                                                               | 25b. REGISTRAR'S SIGNATURE<br>J. E. Lowell Lemmon Padonia                                                               |                                              |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |                                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Howard L. Shipley</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 27, 1987</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>2 P M</b>                                                                        |  |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>White</b>                                                                                                               |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 8, 1900</b>                                                                                                   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>87</b>                                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                                       |                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Ruxton</b> |                                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self employed</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocery</b>                                                                        |  |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br><b>--</b>                                                                                                              |                                                                | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3838 Roland Avenue 21211</b>                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Shipley</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |                                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jane Alban</b>                                                                                          |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215 10 2806</b>                                                         |                                                                | 17. INFORMANT<br><b>Kingsville, Maryland 21087</b><br><b>Harry L. Miller 7622 Gremecy Pk Rd PO Box 97</b>                                                   |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br><b>CVA</b><br><b>ASCVD</b><br><b>X-ray</b> |  |                                                                                                                                       |                                                                |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>—</b>                                                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>None</b>                                                                                                                                                                                                                                |  |                                                                                                                                       |                                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION<br><b>—</b>                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>                                                                          |                                                                |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— P.M. 19</b>                                                                   |                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>                                                                  |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>                                                    |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>— 81 10/27 87</b>                                                                                   |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/1/81</b> to <b>10/27/87</b> , that (I) (we) last saw the deceased alive on <b>10/1/87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)                                                              |  |                                                                                                                                       |                                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Gregory Walker MD</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |                                                                | DEGREE<br><b>MD</b>                                                                                                                                         |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>10/29/87</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Gregory Walker</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       |                                                                | 22e. ADDRESS<br><b>3300 N. Calver St 21218</b>                                                                                                              |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>10/30/87</b>                                                                                                          |                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorriane Park Cemetery</b>                                                                                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Balto. Co. Md.</b>                   |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Burgee-Henss Funeral Home, 3631 Falls Rd 21211</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                                                                | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 30 1987</b>                                                                                                         |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                |  |                                                                                                                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED

SECTION 101

101

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

(TYPE OR PRINT)

MILDRED

SHIPLEY

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

10 27 87

X 3<sup>20</sup> P M

3. SEX

X FEMALE

4. RACE

X WHITE

5. DATE OF BIRTH

X 8 07 04

6. AGE (IN YEARS LAST BIRTHDAY)

X 83

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Tenn.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore Balto. MD.

10. CITY OR TOWN OF DEATH

X Cockeysville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

X MARYLAND MASONIC HOMES

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Balto.

13c. CITY OR TOWN

Owings Mills

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

12319 Greenspring Ave. 21117

14. FATHER'S NAME

Thomas

MIDDLE

Backus

LAST

15. MOTHER'S MAIDEN NAME

Ada

MIDDLE

Litzsinger

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

213-74-8919

17. INFORMANT

ADDRESS

Mrs. Jean Witte, 12319 Greenspring Ave.,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Dementia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that (I) (we) lost

saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

10-29-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

10/30/87

23c. NAME OF CEMETERY OR CREMATORY

Druid Ridge

23d. LOCATION

Pikesville

COUNTY

Balto.

STATE

Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Mitchell-Wiedefeld Home, Inc., 6500 York Rd.

NOV 3 1987

Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove complete pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

100-20 223050

NOV 3 1987

69990 OCT 28 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Marie Elizabeth Shorb</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 16 87</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>M</b>                                                                            |  |                                                                                                                            |  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                   |  | 4 RACE<br><b>White</b>                                                                                                               |                                                        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 3 1922</b>                                                                                                       |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                        |                                                        | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                              |  |                                                                                                                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>Parkville</b>                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8121 Bon Air Rd.</b> |                                                        |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Clerical</b>                                                                       |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                         |                                                        | 13c. CITY OR TOWN<br><b>Parkville</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8121 Bon Air Rd. 21234</b>                                                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmer Collins</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Diefenbach</b>                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>217-12-0106</b>                                                                                       |                                                        | 17. INFORMANT<br>NAME ADDRESS<br><b>Clarence J. Shorb Same as #13.</b>                                                                                      |  |                                                                                                 |  |                                                                                                                            |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Caulicpneumonia Arter</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Mechanistic Pancreatic Cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                      |                                                        |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a                                                                                                                                                                                                                                        |  |                                                                                                                                      |                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                     |                                                        |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                    |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                                               |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                               |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 87</b> to <b>Oct 19 87</b> , that (I) (we) last saw the deceased alive on <b>Oct 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.                                               |  |                                                                                                                                      |                                                        |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Myo Thant</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |                                                        | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                                 |  | 22c. DATE SIGNED<br><b>10-16-87</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Myo Thant</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |                                                        | 22e. ADDRESS<br><b>9101 FRANKLIN SQ. DR. BALTO, MD 21237</b>                                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>10/19/87</b>                                                                                                         |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Pk.</b>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |  |                                                                                                                            |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      |                                                        | ADDRESS<br><b>1050 York Rd.</b>                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1987</b>                                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Towson-Rudolph</b>                                                                   |  |

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must fill in the following details.

BP

70 85 700 7 2 2 0 0

10-25-53

1251

067732 OCT

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                    |  |                                                                                            |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                           |  |                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Abraham</b>                                                                                                                                                                                                                                                                                                                                                                                     |                         | FIRST                                                                                                                              |  | MIDDLE                                                                                     |  | LAST <b>Smith</b>                                                                                                                                        |  | 2a. DATE KNOWN OF DEATH                                                                                 |  | MONTH <b>10</b> DAY <b>3</b> YEAR <b>1987</b>                             |  | 2b. HOUR <b>8:15</b> P.M. |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>11</b> YEAR <b>1904</b>                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                          |  | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                          |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                                        |  | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>10</b> DAY <b>3</b> YEAR <b>1987</b> |  | 2d. HOUR <b>9:00</b> P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va</b>                                                                                                                                                                                                                                                                                                                                                                                 |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                                                       |  |                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore county</b> MD.                                     |  |                                                                           |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                                                                                                                                                                                                                                                                                                                                                                        |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>307 Winters Lane</b> |  |                                                                                            |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                         |  |                           |  |
| 13a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                |                         | 13b. COUNTY<br><b>Baltimore</b>                                                                                                    |  | 13c. CITY OR TOWN<br><b>Catonsville</b>                                                    |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13e. STREET ADDRESS<br><b>307 Winters Lane 21228</b>                                                    |  |                                                                           |  |                           |  |
| 14. FATHER'S NAME<br>FIRST <b>Spencer</b> MIDDLE <b>Smith</b> LAST <b>Anderson</b>                                                                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Julia</b> MIDDLE <b>Anderson</b> LAST <b>Anderson</b> |  |                                                                                                                                                          |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) |  |                                                                           |  |                           |  |
| 16a. SOCIAL SECURITY NO.<br><b>216-05-5995</b>                                                                                                                                                                                                                                                                                                                                                                                         |                         |                                                                                                                                    |  | 17. INFORMANT<br><b>Edward Smith</b>                                                       |  |                                                                                                                                                          |  | ADDRESS<br><b>307 Winters Lane</b>                                                                      |  |                                                                           |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                        |                         |                                                                                                                                    |  |                                                                                            |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                           |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                     |                         |                                                                                                                                    |  |                                                                                            |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                           |  |                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                          |  |                                                                                                                                                          |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |                                                                           |  |                           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                         |                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                          |  |                                                                                                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                           |  |                                                                           |  |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                               |                         |                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                |  |                                                                                                                                                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                       |  |                                                                           |  |                           |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                         |                                                                                                                                    |  |                                                                                            |  |                                                                                                                                                          |  |                                                                                                         |  |                                                                           |  |                           |  |
| ACTUAL SIGNATURE <b>Stanley Z. Felsenberg MD.</b>                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                                    |  | TITLE (SPECIFY)<br>M.D. <b>Deputy</b>                                                      |  |                                                                                                                                                          |  | MEDICAL EXAMINER<br>DATE SIGNED <b>10/4/87</b>                                                          |  |                                                                           |  |                           |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Stanley Z. Felsenberg MD.</b>                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                                                    |  | ADDRESS <b>11 E. Chase St</b>                                                              |  |                                                                                                                                                          |  | 22b. DATE REC'D. BY REGISTRAR                                                                           |  |                                                                           |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                    |  | 23b. DATE<br><b>10/7/87</b>                                                                |  |                                                                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>                                      |  |                                                                           |  |                           |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Arbutus</b>                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                                                    |  | COUNTY<br><b>Md</b>                                                                        |  |                                                                                                                                                          |  | STATE                                                                                                   |  |                                                                           |  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H West</b>                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                                                                                                    |  | ADDRESS<br><b>4300 Wabash Avenue</b>                                                       |  |                                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 06 1987</b>                                                     |  |                                                                           |  |                           |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                                                    |  | 25c. REGISTRAR'S SIGNATURE                                                                 |  |                                                                                                                                                          |  | 25d. REGISTRAR'S SIGNATURE                                                                              |  |                                                                           |  |                           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM V-100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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UNITED STATES

NAVY



NO 100

068528 OCT 17-87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                |                                                                                                                                                            |                                                                                                 |                                                                                                  |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lillian Anne Smith</b>                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                |                                                                                                                                                            | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-7-87</b>                                           |                                                                                                  | 2b. HOUR<br>M<br><b>M</b>                                                                                                  |
| 3 SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                    | 4 RACE<br><b>White</b>                                                                                                                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 13 22</b>                                                                                                       |                                                                                                 | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS                                                  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>                                                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                     | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                               |                                                                                                                            |
| 10 CITY OR TOWN OF DEATH<br><b>Rosedale</b>                                                                                                                                                                                                                                                                                                                                                                                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1314 Rosewick Avenue 21237</b> |                                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaking</b>                                           |                                                                                                                            |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                | 13c. CITY OR TOWN                                                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1314 Rosewick Ave. 21237</b>                                |                                                                                                                            |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur Garman Kendrick</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Younts</b>                                                                               |                                                                                                 |                                                                                                  |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>220-14-0949</b>                                                                                                             |                                                                                                 | 17 INFORMANT ADDRESS<br><b>Patricia A. Langenfelder 11904 Clarksville Pike, Clarksville, Md.</b> |                                                                                                                            |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Probable ventricular tachycardia/fibrillation minutes</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Rheumatic heart disease</b> years |                                                                                                                                                |                                                                                                                                                            |                                                                                                 |                                                                                                  |                                                                                                                            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                                                                                                                                           |                                                                                                                                                |                                                                                                                                                            |                                                                                                 |                                                                                                  |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                           |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                  |                                                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |                                                                                                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                  |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 19</b> 19 <b>80</b> , to <b>Oct 7</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>September 30</b> 19 <b>87</b> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                   |                                                                                                                                                |                                                                                                                                                            |                                                                                                 |                                                                                                  |                                                                                                                            |
| 22b. SIGNATURE<br><b>Paul Tecklenberg</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                | DEGREE<br><b>M.D.</b>                                                                                                                                      |                                                                                                 | 22c. DATE SIGNED<br><b>Oct 7, 1987</b>                                                           |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul Tecklenberg, M.D. (391-2930)</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                | 22e. ADDRESS<br><b>White Sq. Prof. Bldg. 3rd Fl. Suite 317</b>                                                                                             |                                                                                                 |                                                                                                  |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             | 23b. DATE<br><b>10-10-87</b>                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                                                                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |                                                                                                  |                                                                                                                            |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                | ADDRESS<br><b>7401 Bel Air Rd. BALTO. Md. 21236</b>                                                                                                        |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1987</b>                                              |                                                                                                                            |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 2 8 2 8 3

REG. NO.

FOR  
1. STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                       |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mildred Bourne SMITH                                                                                                                                                                                                                                                                          |                                                                                                                                       |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 29, 1987                        |                                                                                                 | 2b. HOUR<br>9:25a M                                                                                                        |
| 1. SEX<br>Female                                                                                                                                                                                                                                                                                                                     | 4. RACE<br>Caucasian                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 28, 1910                                                                                                         |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS                                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Essex                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector  |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Electronics                                                                           |
| 13a. STATE<br>Florida                                                                                                                                                                                                                                                                                                                |                                                                                                                                       |                                                                                                                                                             | 13b. CITY OR TOWN<br>Pasco                                                     | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br>21 Whispering Oaks Drive 34248                                                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John H. Bourne                                                                                                                                                                                                                                                                             |                                                                                                                                       |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ollie V. Jarvis               |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                           |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br>235-22-4453                                                                                                                     |                                                                                | 17. INFORMANT<br>39 Johnson Road<br>Somerset, New York                                          |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Multiple brainstem cerebrovascular accidents<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |                                                                                                                                       |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Seizure disorder, chronic obstructive pulmonary disease                                                                                                                                        |                                                                                                                                       |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                             |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                 |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                       |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                 |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from October 21, 19 87, to October 29, 19 87, that (I) (we) last saw the deceased alive on October 29, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                       |                                                                                                                                                             |                                                                                |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br>James Bloomer                                                                                                                                                                                                                                                                                                      |                                                                                                                                       | DEGREE<br>45                                                                                                                                                |                                                                                | 22c. DATE SIGNED<br>10/29/87                                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James Bloomer, M.D.                                                                                                                                                                                                                                                                         |                                                                                                                                       |                                                                                                                                                             | 22e. ADDRESS<br>9000 Franklin Square Dr., Balto., 21237                        |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                               | 23b. DATE<br>11/2/1987                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Chaple Hill Cem.                                                                                                      |                                                                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dade City Florida                                 |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>M. Gladden Kurtz Jarrettsville, Md.                                                                                                                                                                                                                                                          |                                                                                                                                       |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br>NOV 04 1987                                   |                                                                                                 |                                                                                                                            |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



069977 OCT 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                                      |                                                                                |                                                                                                                            |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HERMAN SOMMERS</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 25 87</b>                         |                                                                                    |                                                                                      |                                                                                |                                                                                                                            | 2b. HOUR<br><b>1<sup>03</sup> P.M.</b>       |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>Caucas.</b>                                                                                                                 |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 11 1896</b>                                                                                                     |                                                                                |                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91 YRS.</b>                                    |                                                                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                           |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                |                                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |                                                                                |                                                                                                                            |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Saint Joseph Hospital</b> |                                                                        |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK, OR MOST OF WORKING LIFE)<br><b>Retired</b> |                                                                                      |                                                                                | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Exxon Corp.</b>                                                                    |                                              |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | 13b. COUNTY<br><b>Baltimore</b>                                                |                                                                                    | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                |                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sommers</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Mueller</b>      |                                                                                    |                                                                                      |                                                                                |                                                                                                                            |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>214-01-4344</b>                                                            |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>William L. Sommers 7726 Wynbrook Rd. 21224</b>                                                                               |                                                                                |                                                                                    |                                                                                      |                                                                                |                                                                                                                            |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cerebrovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>sepsis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                                      |                                                                                |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>                                                                                                                                                                                                                                                     |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                                      |                                                                                |                                                                                                                            |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                |                                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                       |  |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                    |                                                                                      |                                                                                |                                                                                                                            |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                    |                                                                                      |                                                                                |                                                                                                                            |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/25</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                               |  |                                                                                                                                           |                                                                        |                                                                                                                                                             |                                                                                |                                                                                    |                                                                                      |                                                                                |                                                                                                                            |                                              |  |
| 22b. SIGNATURE<br><b>JJ KMETZ</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | DEGREE                                                                         |                                                                                    |                                                                                      | 22c. DATE SIGNED<br><b>10-25-87</b>                                            |                                                                                                                            |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JJ KMETZ MD</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>ST JOSEPH HOSPITAL</b>                                      |                                                                                    |                                                                                      |                                                                                |                                                                                                                            |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           | 23b. DATE<br><b>10-28-87</b>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                 |                                                                                    |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eastwood, Balto. Co., Md.</b> |                                                                                                                            |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles S. Zeiler &amp; Son Inc.</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |                                                                        |                                                                                                                                                             | ADDRESS<br><b>6224 Eastern Ave.</b>                                            |                                                                                    | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1987</b>                                  |                                                                                | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                                                |                                              |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1- DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
ALbert A. Sorensen

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR  
10 8 87 2 AM

3. SEX

male

4 RACE

Caucasian

5 DATE OF BIRTH

MONTH DAY YEAR  
1 4 04

6 AGE (IN YEARS LAST BIRTHDAY)

83

IF UNDER 1 YEAR IF UNDER 24 HRS  
MONTHS DAYS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Minnesota

7b CITIZEN OF WHAT COUNTRY?

USA

MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Balto. county MD

10 CITY OR TOWN OF DEATH

Towson

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Stella Maris Hospice

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Minister, Own

12b KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE Maryland

13b COUNTY

13c CITY OR TOWN Baltimore

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS / ZIP CODE

3701 Greenway, Balto. Md. 21218

14. FATHER'S NAME

FIRST MIDDLE LAST  
Mads P. Sorensen

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Beate Jepsen

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN) No

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.

359-36-9067

17 INFORMANT

ADDRESS

Margaret L. Sorensen, Same as above

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Metastatic Adenocarcinoma of Lung

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)

21f LOCATION

STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 10/16, 19 87, to 10/8, 19 87, that (I) (we) last saw the deceased alive on 10/8, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

Carla S. Alexander

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

10/8/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Carla S. Alexander, M.D.

22e ADDRESS

Stella Maris Hospice  
Dulaney Valley Rd. - Towson, MD 21204

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

10/10/87

23c NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

23d LOCATION

CITY OR TOWN COUNTY STATE  
Baltimore Co. Md.

24 FUNERAL DIRECTOR NAME

Balto. Md. 21230

McCully Funeral Home, 130 E. Fort Ave.

25a DATE REC'D. BY REGISTRAR

OCT 09 1987

25b REGISTRAR'S SIGNATURE

Carla S. Alexander

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

108110 30533

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE 01-10-2001 BY 60322

108110 30533

108110 30533

070264 OCT 29 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                  |                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Evelyn A. Southworth                                                                                                                                                                                                                                                                                                |  |                                                                                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 24 1987                                          |                                                                                                                                                             |                                                                                | 2b. HOUR<br>2:50p <sup>M</sup>                                                                                                             |                                                                  |                                                                                                                            |  |
| 3 SEX<br>Female                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                 |                                                                                                 | 5. DATE OF BIRTH<br>Sept. 17, 1901                                                                                                                          |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86                                                                                                      |                                                                  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS                                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Virginia                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                              |                                                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                               |                                                                  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Franklin Sq. Hospital |                                                                                                 |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORKING LIFE)<br>Housewife                                                                               |                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None                                                                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE CITY OR TOWN<br>Maryland Baltimore                                                                                                                                                                                                                   |  |                                                                                  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                                             | 13c. STREET ADDRESS / ZIP CODE<br>1000 Franklin Ave. Apt. 216 21221            |                                                                                                                                            |                                                                  |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wesley Kephart                                                                                                                                                                                                                                                                                                   |  |                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes Rust                                     |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No -                                                                                                                                                                                                                                                   |  |                                                                                  | 16b. SOCIAL SECURITY NO.<br>261 47 3589                                                         |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>Wilfred Southworth, Husband Same                      |                                                                                                                                            |                                                                  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF, (b) cardiac arrhythmia<br>DUE TO, OR AS A CONSEQUENCE OF, (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                  |                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                         |  |                                                                                  |                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |  |                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |  |                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                                                                            |                                                                  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                        |  |                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                                            |                                                                  |                                                                                                                            |  |
| 22a. I certify that (this hospital) attended the deceased from October 23 1987, to October 24 1987, that (we) lost the deceased alive on October 24 1987, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (not) view the body after death.                                                        |  |                                                                                  |                                                                                                 |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Dr. Liao                                                                                                                                                                                                                                                                                                                                 |  |                                                                                  | DEGREE<br>MD                                                                                    |                                                                                                                                                             |                                                                                | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                  | 22c. DATE SIGNED<br>10/24/87                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Liao                                                                                                                                                                                                                                                                                                          |  |                                                                                  | 22e. ADDRESS<br>9000 Franklin Square Drive                                                      |                                                                                                                                                             |                                                                                |                                                                                                                                            |                                                                  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial                                                                                                                                                                                                                                                                                                                  |  |                                                                                  | 23b. DATE<br>10/27/87                                                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith                         |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md. |                                                                                                                            |  |
| 24. FUNERAL HOME<br>Brazdzinski Funeral Home PA                                                                                                                                                                                                                                                                                                            |  |                                                                                  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1987                                                    |                                                                                                                                                             |                                                                                | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                                                                       |                                                                  |                                                                                                                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified at once.

BP

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Service Virginia

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070505 NOV-28

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                             |           |                                                                                                           |                   |                                                                                                                                                             |                                                                  |                                                                                                                               |                                   |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                         |           | FIRST                                                                                                     | MIDDLE            | LAST                                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR                              |                                                                                                                               | 2b. HOUR<br>M                     |                                                 |
| Catherine                                                                                                                                                                                                                                                                                                                                                                                   |           | E.                                                                                                        |                   | Spedden                                                                                                                                                     | Oct. 28, 1987                                                    |                                                                                                                               |                                   |                                                 |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                      | F         | 4. RACE                                                                                                   | Cauc              | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                          |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS                                                                                        |                                   | IF UNDER 7a HRS<br>MONTHS DAYS HOURS MIN.       |
| June 11, 1893                                                                                                                                                                                                                                                                                                                                                                               |           | 94                                                                                                        |                   |                                                                                                                                                             |                                                                  |                                                                                                                               |                                   |                                                 |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                | MD        | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | USA               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                  |                                   |                                                 |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                   | Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY |                                                 |
| 1330 Westburn Ave 21228                                                                                                                                                                                                                                                                                                                                                                     |           | Restaurant Sales                                                                                          |                   | Self                                                                                                                                                        |                                                                  |                                                                                                                               |                                   |                                                 |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE                                                                                                                                                                                                                                                                                       |           | 13b. COUNTY                                                                                               | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             | 13e. STREET ADDRESS                                              |                                                                                                                               |                                   |                                                 |
| Md                                                                                                                                                                                                                                                                                                                                                                                          |           | Balto                                                                                                     |                   |                                                                                                                                                             | 1330 Westburn Ave 21228                                          |                                                                                                                               |                                   |                                                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                      |           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                                             |                   |                                                                                                                                                             |                                                                  |                                                                                                                               |                                   |                                                 |
| William J. Spedden                                                                                                                                                                                                                                                                                                                                                                          |           | Ellen Mannion                                                                                             |                   |                                                                                                                                                             |                                                                  |                                                                                                                               |                                   |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                        |           | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                                                   |                   | 17. INFORMANT ADDRESS                                                                                                                                       |                                                                  |                                                                                                                               |                                   |                                                 |
| No                                                                                                                                                                                                                                                                                                                                                                                          |           | 213-34-3127                                                                                               |                   | 1330 Westburn Ave 21228<br>Mr. Robert Callahan                                                                                                              |                                                                  |                                                                                                                               |                                   |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) ASCUD CUA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Adeno Carcinoma of Breast<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |           |                                                                                                           |                   |                                                                                                                                                             |                                                                  |                                                                                                                               |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|                                                                                                                                                                                                                                                                                                                                                                                             |           |                                                                                                           |                   |                                                                                                                                                             |                                                                  |                                                                                                                               |                                   |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                      |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                    |           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                  |                                                                                                                               |                                   |                                                 |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                   |           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                  |                                                                                                                               |                                   |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/12, 1987, to 10/28, 1987, that (I) (we) last saw the deceased alive on 10/28, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                                                                 |           | 22b. SIGNATURE<br>Dr. John Shaw                                                                           |                   | DEGREE<br>MD                                                                                                                                                |                                                                  | 22c. DATE SIGNED<br>10/30/87                                                                                                  |                                   |                                                 |
| 22d. PHYSICIAN'S NAME                                                                                                                                                                                                                                                                                                                                                                       |           | 22e. ADDRESS                                                                                              |                   |                                                                                                                                                             |                                                                  |                                                                                                                               |                                   |                                                 |
| Dr. John Shaw                                                                                                                                                                                                                                                                                                                                                                               |           | 5800 Edmondson Ave                                                                                        |                   |                                                                                                                                                             |                                                                  |                                                                                                                               |                                   |                                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                |           | 23b. DATE                                                                                                 |                   | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                    |                                   |                                                 |
| Burial                                                                                                                                                                                                                                                                                                                                                                                      |           | 10/31/87                                                                                                  |                   | New Cathedral Cem.                                                                                                                                          |                                                                  | Baltimore City Md                                                                                                             |                                   |                                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                                        |           |                                                                                                           |                   | 25a. DATE REC'D. BY REGISTRAR                                                                                                                               |                                                                  | 25b. REGISTRAR'S SIGNATURE                                                                                                    |                                   |                                                 |
| Sterling Ashton Funeral Estate, P.A.                                                                                                                                                                                                                                                                                                                                                        |           |                                                                                                           |                   | OCT 30 1987                                                                                                                                                 |                                                                  | Julia...                                                                                                                      |                                   |                                                 |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (filled in) by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other" 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

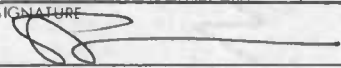
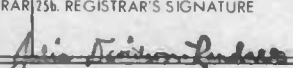
BP



070413 NOV-20

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                     |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Diana Mabel Spivey</b>                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Oct. 29, 1987</b> |                                                                                                                                                             | 2b. HOUR<br><b>10:30 am</b>                                                          |                                                                                                                     |                                                                                                                            |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>White</b>                                                                                                                |                                                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 23, 1899</b>                                                                                                  |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                                                                   |                                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kansas</b>                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                 |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Upperco</b>                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>16012 Trenton Road</b> |                                                             |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home Keeping</b>                                                                   |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        |                                                             | 13b. COUNTY<br><b>Balto.</b>                                                                                                                                |                                                                                      | 13c. CITY OR TOWN<br><b>Upperco</b>                                                                                 |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Sheldon Carpenter</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                        |                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine McIntyre</b>                                                                                  |                                                                                      |                                                                                                                     |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br><b>500-22-0343</b>                                                                                         |                                                             | 17. INFORMANT<br>ADDRESS<br><b>Elbert D. Spivey 800 Regester Ave, Balto., Md. 21239</b>                                                                     |                                                                                      |                                                                                                                     |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Conjunctive Heart Failure</b>                                                                                                                                                                                   |  |                                                                                                                                        |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b>                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                     |                                                                                                                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                     |                                                                                                                            |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                     |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Colon cancer</b>                                                                                                                                                                                         |  |                                                                                                                                        |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                     |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |                                                             |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                      |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                      |                                                                                                                     |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                      |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                 |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                      |                                                                                                                     |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1986</b> to <b>Oct. 29, 1987</b> , that (I) (we) lost<br>saw the deceased alive on <b>Oct 21, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                        |                                                             |                                                                                                                                                             |                                                                                      |                                                                                                                     |                                                                                                                            |  |
| 22b. SIGNATURE<br>                                                                                                                                                                                                                                               |  |                                                                                                                                        |                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                      | 22c. DATE SIGNED<br><b>10/29/87</b>                                                                                 |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Steven Shaffer</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                             | 22e. ADDRESS<br><b>2111 Hanover Pike, Hampstead Md 21074</b>                                                                                                |                                                                                      |                                                                                                                     |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>Oct. 31, 1987</b>                                                                                                      |                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pleasant Grove Cem.</b>                                                                                            |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Upperco, Balto., Md.</b>                                           |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br><b>H. E. Zehlehardt</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                        |                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 30 1987</b>                                                                                                         |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br> |                                                                                                                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. These permits remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, the medical examiner must be notified at once.

BP \_\_\_\_\_

79 S-VOL E 14050

OCT 30 1985

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                                                                |                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| FOR<br>1- STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 28287                                                                                                                                          |                                                                                                                                                             |
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 2b. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                                                                                                      |                                                                                                                                                             |
| FIRST MIDDLE LAST<br>John (nmi) Sredoyer                                                                                                                                                                                                                                                                                                                                                                                                       |                  | MONTH DAY YEAR<br>October 29 87                                                                                                                |                                                                                                                                                             |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br>white | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 1 1910                                                                                                 | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>77 YRS.                                                                                                               |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Phila., Penna.                                                                                                                                                                                                                                                                                                                                                                                 |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                                            |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Marine Engineer                                                                         |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 13b. CITY OR TOWN<br>Cockeysville                                                                                                              | 13c. STREET ADDRESS<br>10304 Gelding Drive 21030                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown Sredoyer                                                                                                                                                                                                                                                                                                                                                                                     |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Unknown                                                                                  |                                                                                                                                                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                                                    |                  | 16b. SOCIAL SECURITY NO.<br>086.12.8339                                                                                                        |                                                                                                                                                             |
| 17. INFORMANT<br>Raymond F. Sparks, Maryland                                                                                                                                                                                                                                                                                                                                                                                                   |                  | 17b. ADDRESS<br>16334 Yeoko Rd. 21152                                                                                                          |                                                                                                                                                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.                                                                                                                                                                                                         |                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Sudden<br>4 1/2 yrs                                                                         |                                                                                                                                                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                |                                                                                                                                                             |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                              |                                                                                                                                                             |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                                                                |                                                                                                                                                             |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                      |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                     |                                                                                                                                                             |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                 |                  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                                                                 |                                                                                                                                                             |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                                                                |                                                                                                                                                             |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Notifiable causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |                                                                                                                                                |                                                                                                                                                             |
| ACTUAL<br>SIGNATURE<br>Charles T O'Donnell, MD                                                                                                                                                                                                                                                                                                                                                                                                 |                  | TITLE (SPECIFY)<br>MEDICAL EXAMINER<br>GMC                                                                                                     |                                                                                                                                                             |
| EXAMINER'S NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                             |                  | DATE SIGNED<br>10/31/87                                                                                                                        |                                                                                                                                                             |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                      |                  | 23b. DATE<br>11/2/1987                                                                                                                         |                                                                                                                                                             |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory                                                                                                                                                                                                                                                                                                                                                                                    |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                                               |                                                                                                                                                             |
| 24. FUNERAL DIRECTOR<br>Walter Brooks Bradley Inc.                                                                                                                                                                                                                                                                                                                                                                                             |                  | 25. DATE REC'D BY REGISTRAR<br>NOV 02 1987                                                                                                     |                                                                                                                                                             |
| 26. ADDRESS<br>Dundalk Md. 21222                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 27. REGISTRAR'S SIGNATURE<br>Julia Sanders-Randall                                                                                             |                                                                                                                                                             |

070021 101-371

John

Chapman

101-371 101-371 101-371

101-371

101-371

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101-371

101-371



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Esther V. Purnell Starkes

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR  
10-22-1987

2b. HOUR

3. SEX

female

4. RACE

black

5. DATE OF BIRTH

2 7 1962

6. AGE (IN YEARS)

25 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

10-22 19 87

2d. HOUR

4:05 M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Md

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County MD

10. CITY OR TOWN OF DEATH

Randallstown

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Baltimore County General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Beautician

12b. KIND OF BUSINESS OR INDUSTRY

12c. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

12d. STATE

Md

12e. COUNTY

Baltimore

13a. INSIDE CITY LIMITS?

YES ☒ NO ☐

13b. STREET ADDRESS

4019 Fairfax Road 21216

14. FATHER'S NAME

Earl

MIDDLE

Purnell

LAST

15. MOTHER'S MAIDEN NAME

Esther

MIDDLE

Johnson

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Earl Purnell

4019 Fairfax Road

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple injuries

DOE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DOE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

Approx. 3:00 PM 10-22-19 87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Driver in auto/auto collision

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

road

21f. LOCATION

Woodlawn Drive and Gwynn Oak Drive, Woodlawn, Baltimore County, MD

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐

Inspection ☐

Inquiry ☐

Baltimore County, MD

death resulted from:

Natural causes ☐

Accident ☒

Suicide ☐

Homicide ☐

Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S NAME (TYPE OR PRINT)

ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

10/27/87

23c. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

23d. LOCATION CITY OR TOWN

Baltimore

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

Wm. C. March F/H West 4300 Wabash Avenue

25a. DATE REC'D BY REGISTRAR

OCT 26 1987

25b. REGISTRAR'S SIGNATURE

Julia Dawson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE MARGINS OF PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

000011 011261

75817 NOTION 20%

CHIEF  
WINTER  
DND





068557 OCT

487  
OR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                          |  |                                                                                               |  |                                                                                  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIVIAN Frances ST. CLAIR</b>                                                              |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 11 87</b>                                        |  | 2b. HOUR<br><b>6 40 AM</b>                                                       |  |
| 3. SEX<br><b>Female</b>                                                                                                                                  |  | 4. RACE<br><b>White CAUCASIAN</b>                                                             |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 02 26</b>                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS                                                                                                         |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland Baltimore</b>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                                        |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore MD.</b>                                  |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                    |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Levindale Geriatric Center</b>           |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>XXX XXXX Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md</b>                                  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>                                                         |  | 13c. CITY OR TOWN<br><b>Towson</b>                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gilbert H. Foreman</b>                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nolia Vayne</b>                           |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  |
| 17. SOCIAL SECURITY NO.<br><b>220-20-9905</b>                                                                                                            |  | 18. INFORMANT<br><b>Nolia Foreman</b>                                                         |  | ADDRESS<br><b>332 Ridge Avenue Towson, MD.</b>                                   |  |

|                                                                                                                                                                                                                                                                      |  |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|                                                                                                                                                                                                                                                                                                                                                    |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |  |                                                                                                                            |  |
| 22a. I certify that (this hospital) attended the deceased from <b>2/2</b> 19 <b>87</b> to <b>10/11</b> 19 <b>87</b> , that (we) last saw the deceased alive on <b>10/11</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we did) (did not) view the body after death. |  |                                                                        |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                               |  | DEGREE<br><b>MD</b>                                                    |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/11/87</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ESTRELITA O. KU</b>                                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS<br><b>LEVINDALE GERIATRIC CENTER - HOSP</b>               |  |                                                                                                                                            |  |                                                                                                                            |  |

|                                                                                                                   |  |                                  |  |                                                                    |  |                                                                         |  |
|-------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|--------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                        |  | 23b. DATE<br><b>Oct 14, 1987</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Cem</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>DIPPEL FUNERAL HOME, INC.<br/>7110 Belair Road Baltimore, MD 21206</b> |  |                                  |  | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1987</b>                 |  | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The day required for completion of this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit when interment is made in a cemetery. Pages 1 and 2 should be retained for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. The funeral director must be notified of the death.

IMPORTANT: If item 21 is marked on item 18 shows only injury or disease and not death, the medical examiner must be notified of the death.

MEDICAL CERTIFICATION

088227 OCT 1981

088227 OCT 1981

088227 OCT 1981

088227 OCT 1981

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                               |  |                                                                                                                                                             |                                                               |                                                                                                 |                                                                                |                                                                                      |                                                                | 8 7 2 8 2 9 2                                                                                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                               |  |                                                                                                                                                             |                                                               |                                                                                                 |                                                                                |                                                                                      |                                                                | REG. NO.                                                                                                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Herbert R. Steiner                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                               |  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 28, 1987       |                                                                                                 |                                                                                |                                                                                      |                                                                | 2b. HOUR<br>2:30 P.M.                                                                                                      |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>W                                                                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 15, 1905                                                                                                        |                                                               |                                                                                                 | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>82 YRS.                                  |                                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                      |                                                                                                                            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>New York                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co., MD                                       |                                                                                |                                                                                      |                                                                |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>13 Maryland Ave. |  |                                                                                                                                                             |                                                               |                                                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Physical Education        |                                                                                                                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                               |  |                                                                                                                                                             |                                                               |                                                                                                 |                                                                                |                                                                                      |                                                                |                                                                                                                            |  |
| 13a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br>Baltimore                                                                                                      |  | 13c. CITY OR TOWN<br>Towson                                                                                                                                 |                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                | 13e. STREET ADDRESS / ZIP CODE<br>13 Maryland Ave. 21204                             |                                                                |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Victor Steiner                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                               |  |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Olga Hoffman |                                                                                                 |                                                                                |                                                                                      |                                                                |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>108 12 7247                                                        |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Helen M. Steiner 13 Maryland Ave. -04                                                                                      |                                                               |                                                                                                 |                                                                                |                                                                                      |                                                                |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Vascular Accidents (multiple)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Days</u><br><u>Yrs</u> |  |                                                                                                                               |  |                                                                                                                                                             |                                                               |                                                                                                 |                                                                                |                                                                                      |                                                                |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><u>Dementia (multiple infarct)</u>                                                                                                                                                                                                                                                                                          |  |                                                                                                                               |  |                                                                                                                                                             |                                                               |                                                                                                 |                                                                                |                                                                                      |                                                                |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                               |                                                                                                 |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                           |  |                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                                |                                                                                      |                                                                |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                |                                                                                      |                                                                |                                                                                                                            |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12-31-1980</u> to <u>Oct 28-1987</u> that (I) (we) last saw the deceased alive on <u>Oct 9, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                               |  |                                                                                                                               |  |                                                                                                                                                             |                                                               |                                                                                                 |                                                                                |                                                                                      |                                                                |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>[Signature]</u><br>DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                               |  |                                                                                                                                                             |                                                               | 22c. DATE SIGNED<br>10-30-87                                                                    |                                                                                |                                                                                      | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. J. VENABLE JR M.D. |                                                                                                                            |  |
| 22e. ADDRESS<br>7215 York Rd. Baltimore MD.                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                               |  |                                                                                                                                                             |                                                               |                                                                                                 |                                                                                |                                                                                      |                                                                |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                               |  | 23b. DATE<br>10/30/87                                                                                                                                       |                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Cem.                                          |                                                                                |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |  |                                                                                                                                                             |                                                               | 25a. DATE REC'D. BY REGISTRAR<br>NOV 3 1987                                                     |                                                                                |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>               |                                                                                                                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, sign any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)



068410 OCT 14 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28293

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                       |  |                                                                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GENEVA</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | FIRST<br><b>ELIZABETH</b>                                                                                                               |  | MIDDLE<br><b>STEVENS</b>                                                                                                                                    |  | LAST                                                                                            |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> <b>10</b> <b>8</b> <b>19</b> <b>87</b> |  | 2b. HOUR<br><b>0200</b>                                                  |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b>                                                                                                                 |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 14 1909</b>                                                                                                    |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>77</b> YRS.                                            |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                                                              |  | 2c. DATE<br>PRONOUNCED<br>DEAD<br><b>10</b> <b>8</b> <b>19</b> <b>87</b> |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>W.VA.</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |                                                                                                                       |  |                                                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1834 Portship Road</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                                                                  |  |                                                                          |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>Balto.</b>                                                                                                            |  | 13c. CITY OR TOWN<br><b>Dundalk</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1834 Portship Road 21222</b>                                                                |  |                                                                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Proud</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lydia Feaster</b>                                                                                       |  |                                                                                                 |  |                                                                                                                       |  |                                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>215-34-8444</b>                                                                                          |  | 17. INFORMANT<br>ADDRESS<br><b>Ethel Legg 961 Kinwatt Ave. 21221</b>                                                                                        |  |                                                                                                 |  |                                                                                                                       |  |                                                                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute intracerebral hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic hypertensive cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 yr</b>                                                                                                                                 |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                       |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                       |  |                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                                                 |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |                                                                          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |                                                                                                                       |  |                                                                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                                                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                       |  |                                                                          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                       |  |                                                                          |  |
| ACTUAL<br>SIGNATURE <b>J. Crossin O'Donovan</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |  | TITLE (SPECIFY)<br><b>Deputy</b> MEDICAL EXAMINER                                                                                                           |  |                                                                                                 |  | DATE<br>SIGNED <b>10/8/87</b>                                                                                         |  |                                                                          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>J. CROSSIN O'DONOVAN</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                         |  | ADDRESS <b>2112 DUNDALK AVE., BALT. MD 21222</b>                                                                                                            |  |                                                                                                 |  |                                                                                                                       |  |                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>1 0/11/87</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosehill Cemetery</b>                                                                                              |  |                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Thomas Tucker West Virginia</b>                                      |  |                                                                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ConnellyFuneralHome</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                         |  | ADDRESS<br><b>300 Mace Ave. 21221</b>                                                                                                                       |  |                                                                                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 13 1987</b>                                                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>via Division Records</i>                |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480</ |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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070667 NOV-1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                            |                                                                                                                                                             |                                                                                     |                                                                                      |                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MARIA LOUISE STOKES                                                                                                                                                                                                                                                  |                                                                                                                                            |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 27, 1987                             |                                                                                      | 2b. HOUR<br>2:55 P.M.                                                                                                         |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                 | 4. RACE<br>White                                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 31, 1889                                                                                                       |                                                                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>98 YRS.                                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Presbyterian Home of Maryland |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Practical Nurse | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medical                                         |                                                                                                                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE Maryland                                                                                                                                                                                                                   |                                                                                                                                            |                                                                                                                                                             | 13b. COUNTY                                                                         | 13c. CITY OR TOWN<br>Baltimore                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>French McCarty Gartrell                                                                                                                                                                                                                                                                |                                                                                                                                            |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Jane Townsend             |                                                                                      |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                                                                                                                                                                                                                           |                                                                                                                                            | 16b. SOCIAL SECURITY NO.<br>216-14-3677                                                                                                                     | 17. INFORMANT ADDRESS<br>Sue Duel, Presbyterian Home of Md.                         |                                                                                      |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Vascular Accident - Recurrent Days<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) - Generalized Arteriosclerosis YRS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                 |                                                                                                                                            |                                                                                                                                                             |                                                                                     |                                                                                      |                                                                                                                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10.                                                                                                                                                                                              |                                                                                                                                            |                                                                                                                                                             |                                                                                     |                                                                                      |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                           |                                                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                          |                                                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                     |                                                                                                                                            | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                     | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                                                                                                                               |
| 22a. I certify that (I) (We) (His Hospital) attended the deceased from July 16, 1988, to Oct 27, 1987, that (I) (we) lost<br>saw the deceased alive on Oct 21, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                            |                                                                                                                                                             |                                                                                     |                                                                                      |                                                                                                                               |
| 22b. SIGNATURE<br>Sidney J. Venable, Jr. M.D.                                                                                                                                                                                                                                                                                    |                                                                                                                                            | DEGREE                                                                                                                                                      |                                                                                     | 22c. DATE SIGNED<br>10-28-87                                                         |                                                                                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sidney J. Venable, Jr. M.D.                                                                                                                                                                                                                                                             |                                                                                                                                            | 22e. ADDRESS<br>7215 York Rd. Baltimore, Md. 21212                                                                                                          |                                                                                     |                                                                                      |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                           |                                                                                                                                            | 23b. DATE<br>10/30/87                                                                                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Patuxent                                      |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sunshine, Montgomery Co., Md.                                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212                                                                                                                                                                                                                                                  |                                                                                                                                            | 4500 York Rd.<br>ADDRESS                                                                                                                                    |                                                                                     | 25a. DATE REC'D. BY REGISTRAR<br>NOV 3 1987                                          | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                                                          |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carboncopiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will use nothing on page 1.



070887 NOV-4 87

20% COTTON FIBER

115 INCHES

NOV 3 1987



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO:

|                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |  |                                                                              |  |                                                               |  |                                              |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|---------------------------------------------------------------|--|----------------------------------------------|--|--------------------------------|--|------------------------------------------|--|---------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------|--|
| 1 - FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                         |  | 2a DECEASED NAME (TYPE OR PRINT)                                                                       |  | 3 SEX                                                                        |  | 4 RACE                                                        |  | 5 DATE OF BIRTH                              |  | 6 AGE (IN YEARS LAST BIRTHDAY) |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) |  | 7b CITIZEN OF WHAT COUNTRY?                                                                 |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |                                                                                                                                                            |  |                                     |  |
| 17 DECEASED NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                |  | FIRST MIDDLE LAST                                                                                      |  | 2b DATE OF DEATH MONTH DAY YEAR                                              |  | 2c HOUR                                                       |  | 3 SEX                                        |  | 4 RACE                         |  | 5 DATE OF BIRTH MONTH DAY YEAR           |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                                              |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                   |  | 7b CITIZEN OF WHAT COUNTRY?         |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |
| Catharine W. Stolka                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |  | 10 23 87                                                                     |  | 12:15pm                                                       |  | F                                            |  | W                              |  | Dec. 6, 1909                             |  | 77 YRS.                                                                                     |  | Md.                                                                                                                                                        |  | USA                                 |  |                                                                                                                                                            |  | Baltimore County MD.                |  |
| 10 CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |  | 13a STATE                                    |  | 13b COUNTY                     |  | 13c CITY OR TOWN                         |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE                                                                                                                              |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| Townson                                                                                                                                                                                                                                                                                                                         |  | Greater Baltimore Medical Center                                                                       |  | Homemaker                                                                    |  |                                                               |  | Md.                                          |  | Baltimore                      |  | Townson                                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  | 614 Fairway Dr. 21204                                                                                                                                      |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| 14 FATHER'S NAME                                                                                                                                                                                                                                                                                                                |  | 15 MOTHER'S MAIDEN NAME                                                                                |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)             |  | 16b SOCIAL SECURITY NO.                                       |  | 17 INFORMANT                                 |  | 18 ADDRESS                     |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| Frank Ward                                                                                                                                                                                                                                                                                                                      |  | Beata McDowell                                                                                         |  | No                                                                           |  | 212 28 5555                                                   |  | Mr. Francis A. Stolka                        |  | 614 Fairway Dr. -04            |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                            |  | IMMEDIATE CAUSE (a)                                                                                    |  | DUE TO, OR AS A CONSEQUENCE OF (b)                                           |  | DUE TO, OR AS A CONSEQUENCE OF (c)                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| Ventricular Fibrillation                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | Respiratory Arrest                                                           |  | C.O.P.D.                                                      |  | 15 minutes                                   |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| 20a DATE OF OPERATION                                                                                                                                                                                                                                                                                                           |  | 20b CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |  | 20c AUTOPSY?                                                                 |  | 20d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                              |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                               |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR                                                            |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                                               |  |                                              |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                           |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |                                                               |  |                                              |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| 22a I certify that (I) (this hospital) attended the deceased from October 19 75, to October 23, 19 87, that (I) (we) last saw the deceased alive on October 23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b SIGNATURE                                                                                          |  | 22c DATE SIGNED                                                              |  |                                                               |  |                                              |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| Myrton Gaines, M.D.                                                                                                                                                                                                                                                                                                             |  | G.B.M.C.                                                                                               |  | 10/23/87                                                                     |  |                                                               |  |                                              |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                        |  | 23b DATE                                                                                               |  | 23c NAME OF CEMETERY OR CREMATORY                                            |  | 23d LOCATION CITY OR TOWN COUNTY STATE                        |  |                                              |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| Entombment                                                                                                                                                                                                                                                                                                                      |  | 10/27/87                                                                                               |  | Moreland Mem. Park                                                           |  | Baltimore, Md.                                                |  |                                              |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| 24 FUNERAL DIRECTOR NAME ADDRESS                                                                                                                                                                                                                                                                                                |  | 25a DATE REC'D BY REGISTRAR                                                                            |  | 25b REGISTRAR'S SIGNATURE                                                    |  |                                                               |  |                                              |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |
| MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.                                                                                                                                                                                                                                                                                     |  | OCT 29 1987                                                                                            |  | Julia Southern-Randall                                                       |  |                                                               |  |                                              |  |                                |  |                                          |  |                                                                                             |  |                                                                                                                                                            |  |                                     |  |                                                                                                                                                            |  |                                     |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                   |  |                                                                                                                                   |                                                        |                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>OLIVER STRAND</b>                                                                                                                                                                                                                       |  |                                                                                                                                   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 28 87</b> |                                                                                                                                                              |  | 2b. HOUR<br><b>4:55 PM</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                              |  |
| 3 SEX<br><b>MALE</b>                                                                                                                                                                                                                                                              |  | 4 RACE<br><b>BLACK</b>                                                                                                            |                                                        | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 13 20</b>                                                                                                          |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS                                                                                                                                                                                                                                                                                           |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>                                                               |  |
| 8. BIRTHPLACE (STATE OR FOREIGN)<br>COUNTRY<br><b>MD</b>                                                                                                                                                                                                                          |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                         |                                                        | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                              |  |
| 12. CITY OR TOWN OF DEATH<br><b>Reisterstown</b>                                                                                                                                                                                                                                  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BENT Nsg Home</b> |                                                        |                                                                                                                                                              |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NA</b>                                                                                                                                                                                                                                                              |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>NA</b>                                                                                |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br><b>MD</b>                                                                                                                                                            |  | 16b. COUNTY<br><b>BALTO.</b>                                                                                                      |                                                        | 16c. CITY OR TOWN                                                                                                                                            |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                            |  | 18. STREET ADDRESS<br><b>21136 12090 Reisterstown Rd</b>                                                                     |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Strand</b>                                                                                                                                                                                                                    |  | 20. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Blackburn</b>                                                            |                                                        |                                                                                                                                                              |  | 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                                                                                                                                                                                                              |  |                                                                                                                              |  |
| 22. SOCIAL SECURITY NO<br><b>219-034541</b>                                                                                                                                                                                                                                       |  | 23. INFORMANT<br><b>Margaret Williams</b>                                                                                         |                                                        |                                                                                                                                                              |  | 24. ADDRESS<br><b>122 N. Caroline St</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                              |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Enteroviral CV Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Years</b> |  |                                                                                                                                   |                                                        |                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                           |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Minutes</b>                                                            |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                               |  |                                                                                                                                   |                                                        |                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                              |  |
| 26. DATE OF OPERATION                                                                                                                                                                                                                                                             |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                        |                                                                                                                                                              |  | 28. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                       |  | 29. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                           |  | 31. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9:34 19 87</b>                                                               |                                                        | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                                |  |                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                              |  |
| 33. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                       |  | 34. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                        | 35. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>11904 Reisterstown Rd Reisterstown Md 21136</b>                                                       |  | 36. I certify that (I) (this hospital) attended the deceased from <b>9-24 1987</b> to <b>10-28 1987</b> , that (I) (we) lost<br>saw the deceased alive on <b>10-27 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death |  |                                                                                                                              |  |
| 37. SIGNATURE<br><b>C. E. Williams</b>                                                                                                                                                                                                                                            |  | 38. DEGREE<br><b>MD</b>                                                                                                           |                                                        | 39. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |  |                                                                                                                                                                                                                                                                                                                                           |  | 40. DATE SIGNED<br><b>10-28-87</b>                                                                                           |  |
| 41. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. E. Williams</b>                                                                                                                                                                                                                     |  | 42. ADDRESS<br><b>11904 Reisterstown Rd Reisterstown Md 21136</b>                                                                 |                                                        |                                                                                                                                                              |  | 43. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                              |  |                                                                                                                              |  |
| 44. DATE<br><b>11/2/87</b>                                                                                                                                                                                                                                                        |  | 45. NAME OF CEMETERY OR CREMATORY<br><b>EASTVIEW MEMORIAL PARK DUNDALK</b>                                                        |                                                        | 46. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MD</b>                                                                                                       |  | 47. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WM. C. MARCH F/H, INC. 1101 E. NORTH AVENUE</b>                                                                                                                                                                                                                                                |  |                                                                                                                              |  |
| 48. DATE REC'D BY REGISTRAR<br><b>OCT 30 1987</b>                                                                                                                                                                                                                                 |  | 49. REGISTRAR'S SIGNATURE<br><b>Julia Sanders</b>                                                                                 |                                                        |                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                              |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 26 plus any injury, or other traumatic event, the physician must also complete the Medical Certificate of Injury.

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

010230 WEA-361

010230 WEA-361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please register with the Baltimore Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 showing injury or other traumatic event, medical examiner will be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                                                                                  |                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. Edward C. Straser</b>                                                                                                                                                                                                                                                                                                |                                                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/24/87</b>                                          |                                                                                                                                                  | 2b. HOUR<br><b>4:48 PM</b>                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br><b>Caucasian</b>                                                                                                                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7/16/05</b>                                                                                                        |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.                                                                                                |                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                              |                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Co. General Hosp.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steam Fitter</b>         |                                                                                                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Local 602</b>                 |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                      | 13b. COUNTY<br><b>Carroll</b>                                                                                                                | 13c. CITY OR TOWN<br><b>Westminster</b>                                                                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                                  | 13e. STREET ADDRESS / ZIP CODE<br><b>412 Oakland Hill Court 21157</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Straser</b>                                                                                                                                                                                                                                                                                                      |                                                                                                                                              |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Engel</b>                              |                                                                                                                                                  |                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-10-7449</b>                                                                               |                                                                                                 | 17. INFORMANT<br><b>Mrs. M. Elizabeth Straser</b><br><b>C70 Mrs. Anna Lee Makovitch</b><br><b>710 Bayberry Circle Westminster Maryland 21157</b> |                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia:</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                    |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                                                                                  |                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                             |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                                                                                  |                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                                           |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                   |                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                        |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                |                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10. 11</b> 19 <b>87</b> , to <b>10. 24</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10. 24</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                                                                                  |                                                                       |  |
| 22b. SIGNATURE<br><b>Agoston R</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                              | DEGREE                                                                                                                                                      |                                                                                                 | 22c. DATE SIGNED<br><b>10.24.87</b>                                                                                                              |                                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYADUR D. GOVINDARA</b>                                                                                                                                                                                                                                                                                               |                                                                                                                                              | 22e. ADDRESS<br><b>BALT County GENL Hospital</b>                                                                                                            |                                                                                                 |                                                                                                                                                  |                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                         |                                                                                                                                              | 23b. DATE<br><b>10/27/87</b>                                                                                                                                |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>                                                                               |                                                                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Prince George's MD</b>                                                                                                                                                                                                                                                                                  |                                                                                                                                              | 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc</b><br>ADDRESS<br><b>8728 Liberty Road Randallstown Maryland 21133</b>               |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 26 1987</b>                                                                                              |                                                                       |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>ma Swisher-Rudner</b>                                                                                                                                                                                                                                                                                                             |                                                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                                                                                  |                                                                       |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                                                                                                      |                                                                                                                                                             |                                                             |                                                                                                 |                                                          |                                                                                                                            |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARIE B. STROCKER                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 7, 1987                                                                                               |                                                                                                                                                             |                                                             | 2b. HOUR<br>2:15p <sup>M</sup>                                                                  |                                                          |                                                                                                                            |                                              |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>White                                                                                                                          |                                                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 24, 1902                                                                                                         |                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS                                                       |                                                          | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                    |                                                                                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |                                                          |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br>Parkville                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Perring Parkway Nursing Home |                                                                                                                                                      |                                                                                                                                                             |                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |                                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                                                              |                                              |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY                                                                                                                               |                                                                                                                                                      | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                          | 13e. STREET ADDRESS / ZIP CODE<br>4304 Willshire Ave. 21206                                                                |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Benjamin Raab                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                           |                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Zango                                                                                                 |                                                             |                                                                                                 |                                                          |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br>(# YES, GIVE WAR OR DATES)<br>216-46-5572                                                                     |                                                                                                                                                      | 17. INFORMANT<br>ADDRESS<br>Anna Temple -3837 Ravenwood Ave., 21213                                                                                         |                                                             |                                                                                                 |                                                          |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                |  |                                                                                                                                           |                                                                                                                                                      |                                                                                                                                                             |                                                             |                                                                                                 |                                                          |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                    |  |                                                                                                                                           |                                                                                                                                                      |                                                                                                                                                             |                                                             |                                                                                                 |                                                          |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                                                                                                                             |                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |  |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                           |                                                                                                                                                             |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                          |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                            |  |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |                                                                                                                                                             |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                          |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 17</u> , 19 <u>86</u> , to <u>Oct 8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Oct 7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                           |                                                                                                                                                      |                                                                                                                                                             |                                                             |                                                                                                 |                                                          |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><u>Timothy Bessent</u>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                           | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                                                             |                                                             | 22c. DATE SIGNED                                                                                |                                                          |                                                                                                                            |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Timothy Bessent, M.D.                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           | 22e. ADDRESS<br>St. Joseph Hospital - Osler Dr. - 21204                                                                                              |                                                                                                                                                             |                                                             |                                                                                                 |                                                          |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                           | 23b. DATE<br>10-10-87                                                                                                                                |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.    |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Baltimore, Maryland                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           | 25a. DATE REC'D. BY REGISTRAR<br>OCT 08 1987                                                                                                         |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u> |                                                                                                 |                                                          |                                                                                                                            |                                              |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit may have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation. If the medical examiner is notified of a death, the medical examiner must be notified of the death. If item 21 is marked or item 18 shows any injury, the medical examiner must be notified of the death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |                                                        |                                                                                                                                                             |  |                                                                                                                               |                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SOPHIE K. SUIT                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 9, 1987 |                                                                                                                                                             |  | 2b. HOUR<br>7:50am                                                                                                            |                                                                                                       |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br>WHITE                                                                                                                   |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DECEMBER 22, 1919                                                                                                     |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.                                                                                    |                                                                                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MASSACHUSETTS                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             |                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                                  |                                                                                                       |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1908 ROLLINGWOOD ROAD |                                                        |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>HOUSEWIFE                                                  |                                                                                                       |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |                                                        |                                                                                                                                                             |  |                                                                                                                               |                                                                                                       |
| 13a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |                                                        | 13b. COUNTY<br>BALTIMORE                                                                                                                                    |  | 13c. CITY OR TOWN<br>CATONSVILLE                                                                                              |                                                                                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HERONIM KUNASZKO                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BRONISLAWA PARZYCH                                                                                         |  |                                                                                                                               |                                                                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>032-09-4495                                                             |                                                        | 17. INFORMANT<br>ADDRESS<br>J. NOEL SUIT SAME AS # 13                                                                                                       |  |                                                                                                                               |                                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cachexia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bowel obstruction from cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Drugs, Cancer</u>                                                                              |  |                                                                                                                                    |                                                        |                                                                                                                                                             |  |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>10/9/87 2 mo</u><br><u>3 mo</u><br><u>18 mo</u> |
|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |                                                        |                                                                                                                                                             |  |                                                                                                                               |                                                                                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                               |  |                                                                                                                                    |                                                        |                                                                                                                                                             |  |                                                                                                                               |                                                                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                         |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                               |                                                                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                             |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                               |                                                                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> , 19 <u>86</u> , to <u>10/9</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                    |                                                        |                                                                                                                                                             |  |                                                                                                                               |                                                                                                       |
| 22b. SIGNATURE<br><u>William C. Waterfield M.D.</u>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                    |                                                        | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>10/9/87</u>                                                                                            |                                                                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WILLIAM WATERFIELD M.D.                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |                                                        | 22e. ADDRESS<br>900 CATON AVENUE, TOWER BLD. BALTIMORE, MD.                                                                                                 |  |                                                                                                                               |                                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>10/12/87                                                                                                              |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>CRESTLAWN                                                                                                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>MARRIOTTSTVILLE MARYLAND                                                        |                                                                                                       |
| 24. FUNERAL DIRECTOR<br>LEROY L. & RUSSELL C. WITZKE FUNERAL HOMES P.A.<br>1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228                                                                                                                                                                                                                                           |  |                                                                                                                                    |                                                        | 25. DATE RECEIVED BY REGISTRAR<br>OCT 13 1987                                                                                                               |  |                                                                                                                               |                                                                                                       |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                       |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                                                            |  | REG. NO. 87 28300                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                     |  | 2a. DECEASED NAME<br>FIRST MIDDLE LAST<br>THEODORE ROOSEVELT Sweetland                                                              |  |                                                                                                                                                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>19 OCT 87                                   |  | 2b. HOUR<br>1:55 P.M.                                                                                                      |  |                                              |  |
| 3 SEX<br>Male                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>white                                                                                                                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 21 02                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS                                          |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                       |  |                                                                                                                            |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Cockeysville                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MARYLAND MASONIC HOMES |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Vice President |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Printing                                                                              |  |                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                     |  | 13b. CITY OR TOWN<br>Baltimore                                                                                                      |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 13d. STREET ADDRESS / ZIP CODE<br>7723 Greenview Terrace 21204                     |  |                                                                                                                            |  |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence Wilmot Sweetland                                                                                                                                                                                                                                                                                        |  |                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Stevens                                                                                               |  |                                                                                    |  |                                                                                                                            |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-09-9088                                                              |  | 17. INFORMANT ADDRESS<br>Mable Day Sweetland Same                                                                                                           |  |                                                                                    |  |                                                                                                                            |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>AAA's &amp; Aortic Aneurysm; Hx M.I.</u>                                                                                                                                                                               |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                                                            |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                    |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                    |  |                                                                                                                            |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                    |  |                                                                                                                            |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ above, (I) (we) (I) (did) (did not) view the body after death _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated                                   |  |                                                                                                                                     |  |                                                                                                                                                             |  |                                                                                    |  |                                                                                                                            |  |                                              |  |
| 22b. SIGNATURE<br><u>Paul M. Rivas</u>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  |                                                                                    |  | 22c. DATE SIGNED<br>10-20-87                                                                                               |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Paul M. Rivas                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                     |  | 22e. ADDRESS                                                                                                                                                |  |                                                                                    |  |                                                                                                                            |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br>Oct. 22, 1987                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Parkville, Balto. Co., Md.           |  |                                                                                                                            |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212                                                                                                                                                                                                                                                                    |  |                                                                                                                                     |  | 25a. DATE REC'D. BY REGISTRAR IN REGISTRAR'S SIGNATURE<br>OCT 23 1987 <u>John Davidson-Randall</u>                                                          |  |                                                                                    |  |                                                                                                                            |  |                                              |  |

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Proposed Project

State of the Project

10-21-07

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                                      |                                                                 |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DOMENICA TAMBURRINO                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 7, 1987                 |                                                                                                                                                             | 2b. HOUR<br>05 30 AM                                            |                                                                                                                                                      |                                                                 |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>White                                                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 11, 1894                                                                                                         |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.                                                                                                           |                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                               |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                                                                        |                                                                 |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>21204                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1554 Doxbury Road 21204 |                                                                        |                                                                                                                                                             |                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                                                                        |                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                                                                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN 21204 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 1554 Doxbury Rd. 21204                                                |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                                      |                                                                 |                                                                                                                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Peter Di Rocco                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna D'Antonio |                                                                                                                                                      |                                                                 |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>----- 214-62-8938                                                         |                                                                        | 17. INFORMANT ADDRESS<br>Mary Tamburrino 1554 Doxbury Rd. 21204                                                                                             |                                                                 |                                                                                                                                                      |                                                                 |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>SIP STROKE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                                      |                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>3 days<br>years                                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                  |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                                      |                                                                 |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                            |  |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                 |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                           |  |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                 |                                                                                                                            |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>July</u> , 19 <u>87</u> , to <u>10-7</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10-6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.           |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                                      |                                                                 |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Joseph W. Zebley</u>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                 | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                 | 22c. DATE SIGNED<br>10-7-87                                                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph W. Zebley, M.D.                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                 | 22e. ADDRESS<br>0-296-4200                                                                                                                           |                                                                 |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      | 23b. DATE<br>OCT. 8, '87                                               |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>DULANEY VALLEY MEM. GAR.  |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CO., MD |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>OCT 07 1987                                                                                                         |                                                                 |                                                                                                                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please reinsertion papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                    |  |                                                                        |  | REG. NO.                                                                                                                |  |                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|---------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                    |  |                                                                        |  | 28302                                                                                                                   |  |                           |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>LLOYD H. TAYLOR</b>                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                    |  |                                                                        |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>October 5, 1987</b>                                                                 |  | 2b. HOUR <b>6:10 p.m.</b> |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                               |  | 4. RACE <b>White</b>                                                                                                                         |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>January 31, 1895</b>                                                                                                  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.                                                     |  | IF UNDER 1 YEAR MONTHS DAYS                                            |  | IF UNDER 24 HRS. HOURS MIN.                                                                                             |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.                                   |  |                                                                        |  |                                                                                                                         |  |                           |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Ruxton Nursing Home</b> |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman -Sterling Supply Co.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |                                                                                                                         |  |                           |  |
| 13a. STATE <b>Florida</b>                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY <b>Sarasota</b>                                                                                                                  |  | 13c. CITY OR TOWN <b>Sarasota</b>                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 13e. STREET ADDRESS / ZIP CODE <b>8705 S. Tamiami Trail 35248</b>      |  |                                                                                                                         |  |                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry T. Taylor</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie M. Holland</b>                                                                                      |  |                                                                                                    |  |                                                                        |  |                                                                                                                         |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 16b. SOCIAL SECURITY NO. <b>WW I 179-03-0410</b>                                                                                                         |  | 17. INFORMANT ADDRESS <b>Elizabeth T. Littleton-2710 Monkton Rd. Monkton, Md. 21111</b>            |  |                                                                        |  |                                                                                                                         |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cerebrovascular Disease</b>                                                                                                                                                 |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                    |  |                                                                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>                                                               |  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                    |  |                                                                        |  |                                                                                                                         |  |                           |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                                                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                    |  |                                                                        |  |                                                                                                                         |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                    |  |                                                                        |  |                                                                                                                         |  |                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  |                                                                                                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                               |  |                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>                                                                                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                     |  |                                                                        |  |                                                                                                                         |  |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                     |  |                                                                        |  |                                                                                                                         |  |                           |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>16 Sep 87</b> to <b>5 Oct 87</b> , that (1) (we) last saw the deceased alive on <b>16 Sep 87</b> , and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |                                                                                                                                              |  |                                                                                                                                                          |  |                                                                                                    |  |                                                                        |  |                                                                                                                         |  |                           |  |
| 22b. SIGNATURE <b>MARC LEAVEY</b>                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | DEGREE <b>M.D.</b>                                                                                                                                       |  |                                                                                                    |  | 22c. DATE SIGNED <b>6 Oct 87</b>                                       |  |                                                                                                                         |  |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARC LEAVEY</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 22e. ADDRESS <b>7600 Osler Dr., Towson, Md. 21204</b>                                                                                                    |  |                                                                                                    |  |                                                                        |  |                                                                                                                         |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 23b. DATE <b>10-7-87</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>              |  |                                                                                                                         |  |                           |  |
| 24. FUNERAL DIRECTOR <b>Ruck Towson Funeral Home, Inc., Towson, Md. 21204</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1987</b>                                                                                                          |  |                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE <b>John F. ...</b>                          |  |                                                                                                                         |  |                           |  |







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back of this certificate, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other", item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

Item 1633 11-3-87  
FOR  
STATE PER FUNERAL HOME SB  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                                                                      |                                                                           |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bertha Katherine Thiell</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-20-87</b>                 |                                                                                                                                                             |                                                                                      | 2b. HOUR<br><b>530</b> A.M.                                                                                                                          |                                                                           |                                                                                                                            |  |
| 3. SEX<br><b>F Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>White</b>                                                                                                                  |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 22, 1898</b>                                                                                             |                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.                                                                                                    |                                                                           | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                                  |                                                                           |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |                                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |                                                                                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retail Sales</b>                  |                                                                                                                            |  |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                          |                                                                        | 13c. CITY OR TOWN<br><b>Towson</b>                                                                                                                          |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                                                           | 13e. STREET ADDRESS<br><b>21204 2400 Dulaney Valley Rd.</b>                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emil Heinerichs Heinerich</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Barbara Pfeifer</b>                                                             |                                                                        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No -</b>                                             |                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>212-34-8869A</b>                                                                                                      |                                                                           | 17. INFORMANT<br>ADDRESS<br><b>Shirley T. Hoeflich, 13408 Manor Rd., 21013</b>                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lower Respiratory Tract congestion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>GENERALIZED ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b> |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                                                                      |                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>MULTI INFARCT DEMENTIA</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                                                                      |                                                                           |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             |                                                                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                           |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                           |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-15</b> , 19 <b>86</b> , to <b>10-20</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>10-19-87</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                    |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                      |                                                                                                                                                      |                                                                           |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Carla A. Alexander</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                      | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                           | 22c. DATE SIGNED<br><b>10/20/87</b>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CARLA A. ALEXANDER</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                      | 22e. ADDRESS<br><b>STELLA MARIS</b>                                                                                                                  |                                                                           |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                          | 23b. DATE<br><b>10/23/87</b>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Luth. Ch. Cem.</b>               |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sweet Air Balto. Md.</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Martin D. Lawson</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                          |                                                                        |                                                                                                                                                             |                                                                                      | 25a. DATE REC'D. BY REGISTRAR<br><b>06183 1987</b>                                                                                                   |                                                                           | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                           |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                        |                                                                                                                                       |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES E. THOMPSON</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                        | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>15</b> YEAR <b>87</b>      |                                                                                                                                                             |                                                                 | 2b. HOUR<br><b>22:50</b> M                                                                                                                 |                                                                        |                                                                                                                                       |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b>                                                                                                                |                                                                        | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>15</b> YEAR <b>09</b>                                                                                             |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                                                                          |                                                                        | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                                                        |                                                                        |                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |                                                                        |                                                                                                                                                             |                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chemical Eng.</b>                                                   |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>                                                                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                        |                                                                                                                                       |  |
| 13a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>Howard</b>                                                                                                           |                                                                        | 13c. CITY OR TOWN<br><b>Ellicott City</b>                                                                                                                   |                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            |                                                                        | 13e. STREET ADDRESS<br><b>8042 Old Montgomery Rd.</b>                                                                                 |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>B.</b> LAST <b>Thompson</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                        |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Alice</b> MIDDLE <b>Rose</b> LAST <b>Welch</b>                                                                         |                                                                 |                                                                                                                                            |                                                                        |                                                                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                        |                                                                        | 16b. SOCIAL SECURITY NO.<br><b>412-01-5617</b>                                                                                                              |                                                                 | 17. INFORMANT<br><b>Alice Rose</b> ADDRESS <b>8042 Old Montgomery Rd. 21043</b>                                                            |                                                                        |                                                                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA + CONGESTION, SEVERE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RIGHT CEREBRAL INFARCT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>THROMBUS, CAROTID ARTERY, RIGHT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                        |                                                                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                       |                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                             |  |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |                                                                                                                                                             |                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                                                        |                                                                                                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                        |                                                                                                                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                          |  |                                                                                                                                        |                                                                        |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                        |                                                                                                                                       |  |
| 22b. SIGNATURE<br><i>Michael E. Pelczar</i>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        | DEGREE <b>MD</b>                                                       |                                                                                                                                                             |                                                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                        | 22c. DATE SIGNED<br><b>10/16/87</b>                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL E. PELCZAR</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                        | 22e. ADDRESS                                                           |                                                                                                                                                             |                                                                 |                                                                                                                                            |                                                                        |                                                                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                        | 23b. DATE<br><b>10-16-87</b>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b> |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md.</b> STATE |                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br><b>Harry H. Witzke</b><br><b>Funeral Home, Inc.</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                        | 4112 Columbia Pike<br><b>Ellicott City, Md. 21043</b>                  |                                                                                                                                                             |                                                                 | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1987</b>                                                                                         |                                                                        |                                                                                                                                       |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              |                                                                                                                                                      |                                                                        |                                                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--|
| REG. NO. 87 28305                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              |                                                                                                                                                      |                                                                        |                                                                                                                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALAN Jude TOWNSEND</b>                                                                                                                                                                                                                                                           |  |                                                                                                                                           |                                                                     |                                                                                                                                                  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCT. 29, 1987</b>                                     |                                                                                                                                                      | 2b. HOUR MIN.<br><b>9:58 AM</b>                                        |                                                                                                                                    |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>WHITE</b>                                                                                                                   |                                                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>SEPT. 17 1948</b>                                                                                          |                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>39</b> YRS                                                                                                     |                                                                        | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.                                                                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                             |                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                                                                                  |                                                                        |                                                                                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH'S HOSPITAL</b> |                                                                     |                                                                                                                                                  |                                                                                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WELDER</b>                                                                       |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>                                                                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>                                                                                                                                                        |  |                                                                                                                                           |                                                                     |                                                                                                                                                  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                                      | 13e. STREET ADDRESS / ZIP CODE<br><b>1700 WESTON AVE. 21234</b>        |                                                                                                                                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>MARION TOWNSEND</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                           |                                                                     |                                                                                                                                                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LEONORA CAPITANO</b>                        |                                                                                                                                                      |                                                                        |                                                                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |                                                                     |                                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br><b>212-46-7767</b>                                               |                                                                                                                                                      | 17. INFORMANT ADDRESS<br><b>LEONORA TOWNSEND (MOTHER) SAME ADDRESS</b> |                                                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b>                                                                                                                                                                                    |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              |                                                                                                                                                      |                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b>                                                                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>DILATED CARDIOMYOPATHY</b>                                                                                                                                                                                                           |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              |                                                                                                                                                      |                                                                        | MONTHS/YEARS                                                                                                                       |  |
| (c)                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              |                                                                                                                                                      |                                                                        |                                                                                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                           |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              |                                                                                                                                                      |                                                                        |                                                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                                                                                                                                  |                                                                                              | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                    |                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                           |  |                                                                                                                                           | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                  |                                                                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                                                       |                                                                        |                                                                                                                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                       |  |                                                                                                                                           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                  |                                                                                              | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                       |                                                                        |                                                                                                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>27. OCT. 19 87</b> to <b>29. OCT. 19 87</b> that (I) (we) last saw the deceased alive on <b>29 OCT. 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              |                                                                                                                                                      |                                                                        |                                                                                                                                    |  |
| 22b. SIGNATURE<br><b>Maurice B Furlong JR MD</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                        | 22c. DATE SIGNED<br><b>29. OCT 87.</b>                                                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MAURICE B FURLONG JR</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              | 22e. ADDRESS                                                                                                                                         |                                                                        |                                                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                           | 23b. DATE<br><b>11/2/87</b>                                         |                                                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>                              |                                                                                                                                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>           |                                                                                                                                    |  |
| 24. FUNERAL HOME<br><b>SCHIMUNEK FUNERAL HOME, INC.</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 1987</b>                                                                                                   |                                                                        |                                                                                                                                    |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |                                                                     |                                                                                                                                                  |                                                                                              |                                                                                                                                                      |                                                                        |                                                                                                                                    |  |



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                    |                                                                                                                                                             |                                                                 |                                                                                                 |                                                             |                                                                                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lena</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                           | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 2 85</b> |                                                                                                                                                             |                                                                 | 2b. HOUR<br><b>11:25 AM</b>                                                                     |                                                             |                                                                                                                               |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>WHITE</b>                                                                                                                   |                                                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 6, 1908</b>                                                                                                   |                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                               |                                                             | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>11 25 00</b>                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GERMANY</b>                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |                                                             |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO. CO. GEN. HOSP.</b> |                                                    |                                                                                                                                                             |                                                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |                                                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                                                           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                     |  |                                                                                                                                           |                                                    |                                                                                                                                                             | APT. 2D                                                         |                                                                                                 |                                                             |                                                                                                                               |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>BALTO.</b>                                                                                                              |                                                    | 13c. CITY OR TOWN<br><b>BALTO</b>                                                                                                                           |                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                             |                                                                                                                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                           |                                                    |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b> |                                                                                                 |                                                             |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>216-30-7133</b>                                                                                            |                                                    | 17. INFORMANT<br><b>MRS. RUTH DIAMOND</b>                                                                                                                   |                                                                 |                                                                                                 |                                                             |                                                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                           |                                                    |                                                                                                                                                             | <b>3423 BIRCH HOLLOW RD. BALTO., MD 21208</b>                   |                                                                                                 |                                                             |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Resp. failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimer's disease C.H.F., Pleural Effusion, CAD</b>            |  |                                                                                                                                           |                                                    |                                                                                                                                                             |                                                                 |                                                                                                 |                                                             | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a                                                                                                                                                                                            |  |                                                                                                                                           |                                                    |                                                                                                                                                             |                                                                 |                                                                                                 |                                                             |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                    |                                                                                                                                                             |                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                             | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                |                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                                 |                                                                                                 |                                                             |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                 |                                                                                                 |                                                             |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                           |                                                    |                                                                                                                                                             |                                                                 |                                                                                                 |                                                             |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>Hafeez A Syed</b>                                                                                                                                                                                                                                                                                      |  | DEGREE                                                                                                                                    |                                                    | 22c. DATE SIGNED<br><b>10/2/87</b>                                                                                                                          |                                                                 |                                                                                                 |                                                             |                                                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFEEZ A SYED M.D.</b>                                                                                                                                                                                                                                                          |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN HOSP.</b>                                                                                         |                                                    |                                                                                                                                                             |                                                                 |                                                                                                 |                                                             |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>OCT. 4, 1987</b>                                                                                                          |                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH TFILOH</b>                                                                                                    |                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |                                                             |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>                                                                                                                                                                                                    |  |                                                                                                                                           |                                                    |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1987</b>              |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |                                                                                                                               |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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COX BOWEN LANE

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2000 10/15/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, a violent traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                     |  |                                                                                                                                               |                                                                   |                                                                                                                                                             |  |                                                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| DECEASED NAME<br>(TYPE OR PRINT) <b>Herman Conrad Trimper</b>                                                                                                                                                                                                                       |  |                                                                                                                                               | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>24</b> YEAR <b>87</b> |                                                                                                                                                             |  | 7b. HOUR<br><b>4:20</b> <sup>a</sup><br>M                                             |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>Caucasian</b>                                                                                                                   |                                                                   | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>09</b> YEAR <b>08</b>                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                    |                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6119 Mt. Ridge Road 21228</b> |                                                                   |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Catonsville</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                                                                                                               |                                                                   | 13e. STREET ADDRESS<br><b>6119 Mt. Ridge Road 21228</b>                                                                                                     |  |                                                                                       |  |
| 14. FATHER'S NAME<br>FIRST <b>Herman</b> MIDDLE <b>Trimper</b> LAST <b>Trimper</b>                                                                                                                                                                                                  |  |                                                                                                                                               |                                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>A.</b> LAST <b>Spano</b>                                                                            |  |                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WWII</b>                                                                           |                                                                   | 17. INFORMANT <b>6121 Mt. Ridge Road</b><br><b>Catherine E. Kirby</b> <b>21228</b>                                                                          |  |                                                                                       |  |

|                                                                                                                                                                                                                                                                                                                                      |  |                                                                        |  |                                                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma lungs metastatic</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>C</u>                                                   |  |                                                                        |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>Carcinoma prostate</u>                                                                                                                                                                    |  |                                                                        |  |                                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/19/80</u> to <u>10/24/87</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/23/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                |  |
| 22b. SIGNATURE<br><u>Malik A. Rehman</u> DEGREE                                                                                                                                                                                                                                                                                      |  |                                                                        |  | 22c. DATE SIGNED<br><u>10/26</u>                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Malik A. Rehman, M.D.</b>                                                                                                                                                                                                                                                                |  |                                                                        |  | 22e. ADDRESS<br><b>2717 Hammonds Ferry Road 21227</b>                          |  |

|                                                                                                  |  |                              |  |                                                                 |  |                                                                                      |  |
|--------------------------------------------------------------------------------------------------|--|------------------------------|--|-----------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>                                       |  | 23b. DATE<br><b>10/27/87</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Ellicott City</b> COUNTY <b>HO.</b> STATE <b>MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>MacNabb Funeral Home</b> ADDRESS <b>301 Frederick Road 21228</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT-26-1987</b>             |  | 25b. REGISTRAR'S SIGNATURE<br><u>John S. ...</u>                                     |  |

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068593 OCT 14 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

28308

REG. NO.

|                                                                                                                                       |                  |                                                |                                                                        |                                                                                                                                                             |                                                                    |                                                                                    |                                                                                                 |                                                |                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FAYE I. TRUMP                                                                                  |                  |                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-6-87                         |                                                                                                                                                             |                                                                    | 2b. HOUR<br>254 PM                                                                 |                                                                                                 |                                                |                                                 |  |
| 3. SEX<br>FEMALE                                                                                                                      | 4. RACE<br>WHITE | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-30-09 |                                                                        | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS                                                                                                                   |                                                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                    |                                                                                                 |                                                |                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WEST VIRGINIA                                                                            |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.         |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                    |                                                                                    |                                                                                                 |                                                |                                                 |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                                          |                  | 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN      |                                                                        |                                                                                                                                                             |                                                                    |                                                                                    |                                                                                                 |                                                |                                                 |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GENERAL |                  |                                                |                                                                        |                                                                                                                                                             |                                                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SCHOOL TEACHER |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>EDUCATION |                                                 |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                               |                  |                                                |                                                                        |                                                                                                                                                             |                                                                    |                                                                                    |                                                                                                 |                                                |                                                 |  |
| 13a. STATE<br>MARYLAND                                                                                                                |                  |                                                | 13b. COUNTY<br>BALTIMORE                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br>CATONSVILLE                                   |                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                | 13e. STREET ADDRESS<br>32 N. ROLLING ROAD 21228 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDWIN BALLARD                                                                               |                  |                                                |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LOU BURGESS       |                                                                                    |                                                                                                 |                                                |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                            |                  |                                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>234-62-6554 |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>EMMA LOU FORD 32 N. ROLLING ROAD 21228 |                                                                                    |                                                                                                 |                                                |                                                 |  |

|                                                                                                                                                                                                                                                                                   |  |                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>END STAGE SEVERE COPD.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                    |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-6-1987</u> to <u>10-6-1987</u> , that (I) (we) last saw the deceased alive on <u>10-6-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                |  |                                                                                                                               |  |
| 22b. SIGNATURE<br><u>R. DEPESTRE</u>                                                                                                                                                                                                                                                                                               |  |                                                                        |  | DEGREE<br>MD                                                                   |  | 22c. DATE SIGNED<br>10-6-87                                                                                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. DEPESTRE                                                                                                                                                                                                                                                                               |  |                                                                        |  | 22e. ADDRESS<br>RANDALLSTOWN, MD.<br>BALTIMORE COUNTY GENERAL HOSPITAL         |  |                                                                                                                               |  |

|                                                                                                            |  |                       |  |                                                  |  |                                                                   |  |                                                  |  |
|------------------------------------------------------------------------------------------------------------|--|-----------------------|--|--------------------------------------------------|--|-------------------------------------------------------------------|--|--------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                     |  | 23b. DATE<br>10/09/87 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BLUE RIDGE |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BECKLEY W. VIRGINIA |  |                                                  |  |
| 24. FUNERAL DIRECTOR<br>LEROY M & RUSSELL C WITZKE FUNERAL HOME<br>1630 EDMONDSON AVE CATONSVILLE MD 21228 |  |                       |  |                                                  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 09 1987                      |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  |

DIVISION OF VITAL RECORDS, 201 W. PINESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15-11-1951 003820

SECRET

Oct 09 1951

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 47 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 when any injury, or other traumatic event, the medical examiner should be notified at 301-359-1234.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                          |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                      |  |                                                                                                                                            |  | REG. NO. 87-28309                                                                                                       |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                        |  | DECEASED NAME (TYPE OR PRINT) <b>Matthew W. Turner</b>                                                                             |  |                                                                                                                                                          |  | 2a. DATE OF DEATH MONTH <b>10</b> DAY <b>11</b> YEAR <b>1987</b>                                                     |  |                                                                                                                                            |  | 2b. HOUR <b>8:00 P.M.</b>                                                                                               |  |  |  |
| 3 SEX <b>Male</b>                                                                                                                                                                                                                                                             |  | 4 RACE <b>Black</b>                                                                                                                |  | 5. DATE OF BIRTH MONTH <b>5</b> DAY <b>13</b> YEAR <b>1925</b>                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62 YRS</b>                                                                        |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>                                                                                                |  | IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>                                                                              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                         |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>                                                     |  |                                                                                                                                            |  |                                                                                                                         |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Saint Agnes Hospital</b> |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Motor Vehicle Operator</b>                          |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>                                                                                         |  |                                                                                                                         |  |  |  |
| 13a. STATE <b>Maryland</b>                                                                                                                                                                                                                                                    |  | 13b. COUNTY <b>Balto</b>                                                                                                           |  | 13c. CITY OR TOWN <b>Catonsville</b>                                                                                                                     |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  | 13e. STREET ADDRESS / ZIP CODE <b>104 Winters Lane 21228</b>                                                                               |  |                                                                                                                         |  |  |  |
| 14. FATHER'S NAME FIRST <b>Matthew</b> MIDDLE <b></b> LAST <b>Turner</b>                                                                                                                                                                                                      |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Helen</b> MIDDLE <b></b> LAST <b>Harris</b>                                                                            |  |                                                                                                                      |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>                                                                |  |                                                                                                                         |  |  |  |
| 16b. SOCIAL SECURITY NO. <b>220-14-1292</b>                                                                                                                                                                                                                                   |  |                                                                                                                                    |  | 17. INFORMANT <b>Sara Turner</b>                                                                                                                         |  |                                                                                                                      |  | ADDRESS <b>104 Winters Lane Catonsville, MD 21228</b>                                                                                      |  |                                                                                                                         |  |  |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> (b) <b>Failure of Pathway with Congestive Atrial Fibrillation</b> (c) <b>Renal Insufficiency</b>              |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                      |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9/14/87 at 44 years 4 yrs.</b>                                          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1                                                                                                                                               |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                      |  |                                                                                                                                            |  |                                                                                                                         |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  |                                                                                                                      |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                             |  |                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>                                                                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                                       |  |                                                                                                                                            |  |                                                                                                                         |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                        |  |                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) <b>9/14/87</b>                                                                          |  | 21f. LOCATION STREET <b>104 Winters Lane</b> CITY OR TOWN <b>Catonsville</b> COUNTY <b>Baltimore</b> STATE <b>MD</b> |  |                                                                                                                                            |  |                                                                                                                         |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/2/87</b> saw the deceased alive on <b>10/2/87</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |                                                                                                                                    |  |                                                                                                                                                          |  |                                                                                                                      |  |                                                                                                                                            |  |                                                                                                                         |  |  |  |
| 22b. SIGNATURE <b>W E McGrath MD</b>                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | DEGREE <b>MD</b>                                                                                                                                         |  |                                                                                                                      |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>10/13/87</b>                                                                                        |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W E McGrath MD</b>                                                                                                                                                                                                                   |  |                                                                                                                                    |  | 22e. ADDRESS <b>1303 Frederick Rd Catonsville 21225 MD</b>                                                                                               |  |                                                                                                                      |  |                                                                                                                                            |  |                                                                                                                         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                       |  | 23b. DATE <b>10-15-87</b>                                                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>                                                                                          |  |                                                                                                                      |  | 23d. LOCATION CITY OR TOWN <b>Arbutus</b> COUNTY <b>Baltimore</b> STATE <b>Maryland</b>                                                    |  |                                                                                                                         |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Nutter Funeral Homes, Inc.</b>                                                                                                                                                                                                                   |  |                                                                                                                                    |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 19 1987</b>                                                                                                         |  |                                                                                                                      |  | 25b. REGISTRAR'S SIGNATURE <b>Tridson Randers</b>                                                                                          |  |                                                                                                                         |  |  |  |

500 100 000 000

067812 OCT 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                    |  |                                                                                      |                                                            |                                                                                                                                                             | REG. NO.                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Adeline Martha Valentine</b>                                                                                                                                                                                                                                                                  |  |                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Oct. 3, 1987</b> |                                                                                                                                                             | 2b. HOUR<br><b>7 a</b> M |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>White</b>                                                              |                                                            | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 30, 1903</b>                                                                                                 |                          |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                                                                                                                                                                                                                                                                                       |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                         |                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                        |  | 9b. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                 |                                                            | 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                                                                                             |                          |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Nursing Center</b>                                                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                           |                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Md.</b>                                                                                                                                                                                                                |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                   |                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                          |  |
| 14. FATHER'S NAME<br><b>Rufus W. Fritz</b>                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br><b>Sadie Musser</b>                                      |                                                            | 16. STREET ADDRESS / ZIP CODE<br><b>117 Clarendon Ave. 21208</b>                                                                                            |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>219-30-2232</b>                                       |                                                            | 17. INFORMANT<br><b>Shirley Rote</b>                                                                                                                        |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CEREBRAL THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MALNUTRITION - DEHYDRATION</b>                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                         |                                                            |                                                                                                                                                             |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                     |  |                                                                                      |                                                            |                                                                                                                                                             |                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7-17 19 67</b>                 |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)                                                                             |                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-17 19 67</b> , to <b>10-3 19 87</b> , that (I) (we) last saw the deceased alive on <b>9-28 19 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                      |                                                            |                                                                                                                                                             |                          |  |
| 22b. SIGNATURE<br><b>Samuel P. Scaccia, MD</b>                                                                                                                                                                                                                                                                                          |  | 22c. DATE SIGNED<br><b>10-5-87</b>                                                   |                                                            | 22d. ADDRESS<br><b>7 CHURCH LAKE 21208</b>                                                                                                                  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>Oct. 6, 1987</b>                                                     |                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Memorial Gar.</b>                                                                                        |                          |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Finksburg, Carroll, Md.</b>                                                                                                                                                                                                                                                            |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>H. Zehlhardt</b>                                  |                                                            | 25. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE)<br><b>OCT 05 1987</b>                                                                               |                          |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                            |  |                                                                                                                                 |                                                   |                                                                                                                                                             |  |                                                                               |  |                                                                                                 |  |
|----------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary Elizabeth VAN AELST            |  |                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 12 87 |                                                                                                                                                             |  | 2b. HOUR<br>M<br>---                                                          |  |                                                                                                 |  |
| 3. SEX<br>Female                                                           |  | 4. RACE<br>White                                                                                                                |                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 12 09                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>---                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                             |                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |  |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Lansdowne                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2119 Gaylawn Drive |                                                   |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>---                                                        |  |
| 13a. STATE<br>Maryland                                                     |  |                                                                                                                                 |                                                   | 13b. COUNTY<br>Baltimore                                                                                                                                    |  | 13c. CITY OR TOWN<br>Lansdowne                                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Hamer                       |  |                                                                                                                                 |                                                   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unknown                                                                                                    |  |                                                                               |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---                                                                  |                                                   | 17. INFORMANT<br>ADDRESS<br>Jonnie VanAelst, 7722 Notley Road                                                                                               |  |                                                                               |  |                                                                                                 |  |

|                                                                                                                                                                   |  |                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASCD</u>                                                 |  |                                                 |  |
| (c) <u>Diabetes Mellitus - osteoporosis</u>                                                                                                                       |  |                                                 |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                     |  |                                                                                                                                                      |  |                                                                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) ( <del>was</del> <u>was not</u> ) attended the deceased from <u>10/12</u> , 19 <u>87</u> , to <u>10/12</u> , 19 <u>87</u> , that (I) ( <del>was</del> <u>was not</u> ) saw the deceased alive on <u>10/12</u> , 19 <u>87</u> , and that in (my) ( <del>was</del> <u>was not</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> <u>was not</u> ) did not view the body after death. |  |                                                                     |  |                                                                                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>John H. Shaw</u>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                     |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>10/13/87</u>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Shaw John H.                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                     |  | 22e. ADDRESS<br>5800 Edmondson Avenue Bal. Md. 21228                                                                                                 |  |                                                                                                                            |  |

|                                                                                             |  |                       |  |                                                              |  |                                                                      |  |
|---------------------------------------------------------------------------------------------|--|-----------------------|--|--------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                      |  | 23b. DATE<br>10/16/87 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Baltimore Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Hubbard Funeral Home, Inc., 4107 Wilkens Ave. 21229 |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1987                 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Denison-Randall</u>                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please return the remaining pages to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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068090 OCT-87

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 2 8 3 1 2

REG. NO.

1 DECEASED NAME FIRST MIDDLE LAST  
(TYPE OR PRINT) CHRISTOPHER G. VARDOLAKIS

2a DATE OF DEATH MONTH DAY YEAR 10 01 '87 2b HOUR 2:20P

3 SEX MALE 4 RACE CAUC 5. DATE OF BIRTH MONTH DAY YEAR 12 14 30 6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.

10 CITY OR TOWN OF DEATH TOWSON 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES ST. 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Estimator- Abington Welding Co. 12b. KIND OF BUSINESS OR INDUSTRY

13a STATE Maryland 13b. CITY OR TOWN Baltimore 13c. INSIDE CITY LIMITS? YES ☒ NO ☐ 13d STREET ADDRESS / ZIP CODE 3905 Dudley Ave. 21213

14 FATHER'S NAME FIRST MIDDLE LAST George Vardoulakis 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Lemons

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes 16b SOCIAL SECURITY NO. Korean 214-26-2770 17 INFORMANT ADDRESS Deborah Vardoulakis - same as #13e

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE LUNG  
DUE TO, OR AS A CONSEQUENCE OF (b) METASTASIZE  
DUE TO, OR AS A CONSEQUENCE OF (c)  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a

19a DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/28, 19 87, to 10/01, 19 87, that (I) (we) lost saw the deceased alive on 10/01, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE G. Kamishev, M.D. DEGREE 22c. DATE SIGNED 10/01/87 ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAMISHEV, M.D. 22e. ADDRESS GBMC-6701 N. CHARLES ST.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 10-5-87 23c. NAME OF CEMETERY OR CREMATORY Parkwood 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md.

24 FUNERAL DIRECTOR Ruck Towson Funeral Home, Inc., Towson, Md. 21204 25a. DATE REC'D. BY REGISTRAR OCT 06 1987 25b. REGISTRAR'S SIGNATURE

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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CHAFETZ • RACE-CLASS

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

070292 OCT 30 1987

|                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                |                                                                                                                                                             |                                                                                                                            |                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ROSE VINCENT                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 24 87                                                                                                             |                                                                                                                            | 2b. HOUR<br>9:02 AM                                           |
| 1. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br>W                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 18 86                                                                                                               |                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>101 YRS                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Canada                                                                                                                                                                                                                                                                                                                                                       | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CO. MD.                                                                  |                                                               |
| 10. CITY OR TOWN OF DEATH<br>DUNDALK                                                                                                                                                                                                                                                                                                                                                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MERIDIAN HERITAGE |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                                              | 12b. KIND OF BUSINESS OR INDUSTRY                             |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                          | 13b. COUNTY<br>Howard                                                                                                          | 13c. CITY OR TOWN<br>ELLICOTT                                                                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       | 13e. STREET ADDRESS / ZIP CODE<br>12256 CARROLL MILL RD 21043 |
| 14. FATHER'S NAME<br>First Middle Last<br>Joseph Therrien                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Aurore Gagnon                                                                                              |                                                                                                                            |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>001-14-0711                                                         | 17. INFORMANT<br>John Allard 14127 Blenheim Rd.<br>Phoenix, Maryland 21131                                                                                  |                                                                                                                            |                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                                                |                                                                                                                                                             |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):                                                                                                                                                                                                                                                                      |                                                                                                                                |                                                                                                                                                             |                                                                                                                            |                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |                                                                                                                            |                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                                                            |                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                  |                                                                                                                                |                                                                                                                                                             |                                                                                                                            |                                                               |
| 22b. SIGNATURE<br>Theodore Patterson MD                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        | 22c. DATE SIGNED<br>10/24/87                                                                                               |                                                               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>THEODORE PATTERSON                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                | 22e. ADDRESS                                                                                                                                                |                                                                                                                            |                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial-Transit                                                                                                                                                                                                                                                                                                                                                         | 23b. DATE<br>10/28/87                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary                                                                                                           | 23d. LOCATION<br>City or Town County State<br>Manchester, Hillsborough N.H.                                                |                                                               |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home, Inc.                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1987                                                                                                                |                                                                                                                            | 25b. REGISTRAR'S SIGNATURE                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 does not specify injury, or other traumatic event, the medicare examiner must be notified at once.

BP

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR  
 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
 MARVIN CHESLEY VOLPEL  
 2a. DATE KNOWN OF DEATH MONTH DAY YEAR HOUR  
 2b. DATE OF ESTI-MATED DEATH MONTH DAY YEAR HOUR  
 3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.  
 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐  
 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.  
 10. CITY OR TOWN OF DEATH Towson 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dulaney/Towson Nursing Home 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Math Professor 12b. KIND OF BUSINESS OR INDUSTRY Education  
 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS 60 Acorn Circle Apt 203 21204  
 14. FATHER'S NAME FIRST MIDDLE LAST John Volpel 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Cominator  
 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. 350-18-2921 17. INFORMANT ADDRESS 21204 Margaret R. Volpel 60 Acorn Cir. Apt 203  
 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I DEATH WAS CAUSED BY:  
 888 IMMEDIATE CAUSE (a) Dehydration  
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  
 (b) Fractured Hip  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c) ASCVD  
 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days  
 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
 19a. DATE OF OPERATION 9-18-87 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Left Hip/ Hip was pinned 20. AUTOPSY? YES ☐ NO ☒  
 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9-17 1987 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Patient fell in hallway at nursing home  
 21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Dulaney/Towson N.H. 21f. LOCATION CITY OR TOWN COUNTY STATE Towson Balto. Md.  
 22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐  
 ACTUAL SIGNATURE Charles F. O'Donnell MEDICAL EXAMINER DATE SIGNED 10/16/87  
 EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell ADDRESS 7501 York Road 21204  
 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 10-13-87 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley 23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Baltimore Maryland  
 24. NAME OF FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Road 21212 25a. DATE REC'D. BY REGISTRAR OCT 14 1987 25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the doctor must be notified of this.

069480 OCT 23 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 7 2 8 3 1 5

REG. NO.

1. FOR  
STATE  
REGISTRAR2. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

FRANK T. vonRINTELN, SR.

7a. DATE OF DEATH

MONTH

DAY

YEAR

10 18 87

7b. HOUR

10:15p<sub>M</sub>

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

May 3, 1905

6. AGE (IN YEARS LAST BIRTHDAY)

82

YRS.

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

MD

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE COUNTY

MD

10. CITY OR TOWN OF DEATH

TOWSON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
6701 N. CHARLES ST.-GBMC

12a. US PROFESSION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
Executive

12b. KIND OF BUSINESS OR INDUSTRY

Fuel Oil Co.

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

BALTO.

13c. CITY OR TOWN

Balto.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

110 W. 39th St., 21210

Apt. 801

14. FATHER'S NAME

August

MIDDLE

Adolph vonRinteln

15. MOTHER'S MAIDEN NAME

Teresa

MIDDLE

Muller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)  
No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)  
416 10 8221

17. INFORMANT

ADDRESS

Mrs. Agnes vonRinteln,

Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

PNEUMONIA

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/18, 19 87, to 10/18, 19 87, that (I) (we) last

saw the deceased alive on 10/18, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

10/18/87

22d. PHYSICIAN'S NAME (PRINT)

22e. ADDRESS

PATRICK DONO, M.D.

GBMC-6701 N. CHARLES ST.

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Cremation

23b. DATE

10/21/87

23c. NAME OF CEMETERY OR CREMATORY

Green Mount

23d. LOCATION

CITY OR TOWN

COUNTY

MD

STATE

24. FUNERAL DIRECTOR

NAME

H.W. Jenkins &amp; Sons Co.

25a. DATE REGISTERED IN REGISTRAR'S OFFICE

OCT 21 1987

006/80 01331

WATERBURY COUNTY

006/80 01331

068230 OCT -9 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 2 3 3 1 6

FOR  
STATE  
REGISTRAR

REG. NO

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                           |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | FIRST<br>ANNA                                                                     |  | MIDDLE<br>MARIE                                                                                                                                             |  | LAST<br>WALTER                                                                                  |  | 2a. DATE OF DEATH<br>MONTH YEAR DAY                                                                                        |  | 2b. HOUR                                  |  |                                              |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>WHITE                                                                  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 06 1922                                                                                                            |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>65 YRS                                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |  | IF UNDER 24 HRS<br>HOURS MIN.             |  |                                              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |                                                                                                                            |  |                                           |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>ROSEDALE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>7906 OAKDALE AVE 21237 |  |                                                                                                                                                             |  |                                                                                                 |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME |  |                                              |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                           |  |                                              |  |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br>BALTO                                                              |  | 13c. CITY OR TOWN<br>ROSEDALE                                                                                                                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7906 OAKDALE AVE 21237                                                                   |  |                                           |  |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM --- THOMAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                   |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELSIE MARY LITTLE                              |  |                                                                                                                            |  |                                           |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES IF UNKNOWN) NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) n/a                       |  | 17. INFORMANT<br>ADDRESS<br>216122563 GEORGE A. WALTER SR 7906 OAKDALE AVE                                                                                  |  |                                                                                                 |  |                                                                                                                            |  |                                           |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Ischemic Cardiomyopathy<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerotic Heart Disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no |  |                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                           |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                  |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                           |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                 |  |                                                                                                                            |  |                                           |  |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                 |  |                                                                                                                            |  |                                           |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1976, to Oct. 07, 1987, that (I) (we) lost<br>saw the deceased alive on Oct. 05, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                            |  |                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                                                                            |  |                                           |  |                                              |  |
| 22b. SIGNATURE<br>T-J. PAGLINACAN, MD<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  | 22c. DATE SIGNED<br>10-7-87                                                                                                |  |                                           |  |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T-J. PAGLINACAN, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                   |  |                                                                                                                                                             |  |                                                                                                 |  | 22e. ADDRESS<br>8552 PHILA. RD., BALTO., MD 37                                                                             |  |                                           |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>10/10/87                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BELAIR MEMORIAL                                                                                                       |  |                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BEL AIR HARFORD MD                                                           |  |                                           |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>C. J. [unclear]<br>ADDRESS<br>1211 Chesapeake                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                   |  |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 08 1987                                                    |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                                                       |  |                                           |  |                                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be  
emailed by the hospital or attending physician.  
1  
TO FUNERAL DIRECTOR. After this certificate has been signed by the physician and completely filled in by the funeral director, page 3  
should be detached for use as the burial transit permit. Then please return the certificate to the funeral directors. Pages 1 and 2 should be filed with the 72 hours after death  
with the State Dept of Health and Mental Hygiene prior to burial, cremation or other disposal.  
IMPORTANT: If item 21 is marked or item 18 has any injury, or after traumatic death, the medical examiner must be notified at once.



067584 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                       |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                           |  | REG. NO.                                                                                                                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>THELMA R. WALTER                                                                                                                                                                                                                                                                  |  |                                                                                                                              |  |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 1, 1987                                                                                                  |  |                                                                           |  | 2b. HOUR<br>10:47 AM                                                                                                       |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>White                                                                                                             |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>09 29 05                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 82 YRS                                                                                                         |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                 |  | IF UNDER 24 HRS                                                                                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                          |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                                                         |  |                                                                           |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST Joseph Hospital |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>at home                              |  |                                                                                                                            |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br>Baltimore                                                                                                     |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                      |  | 13e. STREET ADDRESS / ZIP CODE<br>6308 Holly Lane Apt. D 21212            |  |                                                                                                                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Kurt                                                                                                                                                                                                                                                                                                |  |                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Janet Cowan                                                                                                   |  |                                                                                                                                                      |  |                                                                           |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>213-32-0988                                                          |  | 17. INFORMANT ADDRESS<br>Charles L. Walter, Sr. 6308 Holly Lane                                                                                             |  |                                                                                                                                                      |  |                                                                           |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sudden cardiac arrest due to cardiac arrhythmia<br>DUE TO, OR AS A CONSEQUENCE OF (b) severe aortic CHD, atrial fibrillation + recent CVA<br>DUE TO, OR AS A CONSEQUENCE OF (c) COPD - contributing cause |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                         |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                           |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                                                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                         |  |                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                       |  |                                                                           |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT SHOWN <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                |  |                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                         |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                       |  |                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from September 25, 1987, to October 1, 1987, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |                                                                                                                              |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                           |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Natividad D. de Leon, M.D.                                                                                                                                                                                                                                                                                               |  |                                                                                                                              |  |                                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/1/87                                               |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NATIVIDAD D. DE LEON                                                                                                                                                                                                                                                                              |  |                                                                                                                              |  |                                                                                                                                                             |  | 22e. ADDRESS<br>20 ST. JOSEPH HOSPITAL, TOWSON, MD. 21204                                                                                            |  |                                                                           |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br>10-5-1987                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial                                                                                                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                                                                             |  |                                                                           |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J. Ruck, Inc.                                                                                                                                                                                                                                                                                         |  |                                                                                                                              |  |                                                                                                                                                             |  | ADDRESS<br>5305 Harford Rd.                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 2 1987                               |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Dander-Randner                                                                         |  |

MEMORANDUM  
TO : [illegible]  
FROM : [illegible]  
SUBJECT : [illegible]  
DATE : [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several paragraphs of text, some of which are indented, suggesting a list or a detailed account. The text is mirrored across the page, likely due to bleed-through from the reverse side.]

069389 OCT 22 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 7 2 8 3 1 8

|                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                            |                                                                                                 |                                                                               |                                                                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VERONICA B. WALTER</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-19-1987</b>               |                                                                                                                                                             |                                                            | 2b. HOUR<br><b>7:56 PM</b>                                                                      |                                                                               |                                                                                                                               |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>WHITE</b>                                                                                                              |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-05-1907</b>                                                                                                     |                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>-80-</b>                                                  |                                                                               | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>CATONSVILLE, MD.</b>                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                        |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CO. MD.</b>                                   |                                                                               |                                                                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSP.</b> |                                                                        |                                                                                                                                                             |                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TELEPHONE OPERATOR</b>   |                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |  |
| 13a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>BALTO. CO.</b>                                                                                                     |                                                                        | 13c. CITY OR TOWN<br><b>PARKVILLE</b>                                                                                                                       |                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                               | 13e. STREET ADDRESS<br><b>APT 29<br/>8 TADMORE CT. 21224</b>                                                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DANIEL MCSWEENEY</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY O'BRIEN</b>                                                                                        |                                                            |                                                                                                 |                                                                               |                                                                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                      |                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-18-5603</b>                                                                               |                                                            | 17. INFORMANT<br>ADDRESS<br><b>- FAMILY RECORDS -</b>                                           |                                                                               |                                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>                                |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                            |                                                                                                 |                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>COPD - HYPERTENSION</b>                                                                                                                                                                                                  |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                            |                                                                                                 |                                                                               |                                                                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                               | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                           |  |                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                               |                                                                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                          |  |                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                               |                                                                                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-17</b> , 19 <b>78</b> , to <b>8-20</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>8-20</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                            |                                                                                                 |                                                                               |                                                                                                                               |  |
| 22b. SIGNATURE<br><b>My Karacuschansky</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                            | DEGREE<br><b>M.D.</b>                                                                           |                                                                               | 22c. DATE SIGNED<br><b>10-21-1987</b>                                                                                         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. KARACUSCHANSKY</b>                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                            | 22e. ADDRESS<br><b>300 E. 33RD STREET, BALTO. MD</b>                                            |                                                                               |                                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      | 23b. DATE<br><b>10-22-1987</b>                                         |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM.</b> |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. CO. MD.</b> |                                                                                                                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPEL OF MEMORIES</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |                                                                        |                                                                                                                                                             |                                                            | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1987</b>                                             |                                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                                                   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove catonsville papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                             |                                                                                                 |                                                                |                                                                                                                            | REG. NO.                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Merlin E WANTLAND                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 6, 1987                                                                                     |                                                                             |                                                                                                 | 7b. HOUR<br>1:30 PM                                            |                                                                                                                            |                                              |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 27 03                                                                                                              |                                                                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.                                  |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |                                                                                                                            | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                |                                                                                                 |                                                                |                                                                                                                            |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |                                                                        |                                                                                                                                                             |                                                                                                                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                              |                                                                                                                            |                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       | 13b. COUNTY<br>--                                                      |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore                                                                                                             |                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                | 13e. STREET ADDRESS / ZIP CODE<br>3014 Mary Avenue 21214                                                                   |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Henry Wantland                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Doria Anderson                                                                            |                                                                             |                                                                                                 |                                                                |                                                                                                                            |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>--          |                                                                                                                                                             | 17. INFORMANT ADDRESS<br>Karen Wantland 3014 Mary Avenue 21214                                                                             |                                                                             |                                                                                                 |                                                                |                                                                                                                            |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory failure.<br>DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last. |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                             |                                                                                                 |                                                                |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a                                                                                                                                                                                                                                         |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                             |                                                                                                 |                                                                |                                                                                                                            |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                            |                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                  |  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                                                             |                                                                                                 |                                                                |                                                                                                                            |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                              |  |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                             |                                                                                                 |                                                                |                                                                                                                            |                                              |  |
| 22a. I certify that (this hospital) attended the deceased from September 28, 1987, to October 6, 1987, that (we) last saw the deceased alive on October 6, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                 |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                            |                                                                             |                                                                                                 |                                                                |                                                                                                                            |                                              |  |
| 22b. SIGNATURE<br>I. Bshara                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                       | DEGREE<br>M.D.                                                         |                                                                                                                                                             | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                             |                                                                                                 | 22c. DATE SIGNED<br>10/6/87                                    |                                                                                                                            |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Irbahim Bshara, M.D.                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br>9000 Franklin Square Dr., Balto., 21237                                                                                    |                                                                             |                                                                                                 |                                                                |                                                                                                                            |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       | 23b. DATE<br>10/10/87                                                  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Cemetery                                                                                  |                                                                             |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hampden Maryland |                                                                                                                            |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz, Jr.                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | ADDRESS<br>3818 Roland Avenue 21211                                                                                                        |                                                                             | 25a. DATE REC'D BY REGISTRAR<br>OCT 8 1987                                                      |                                                                | 25b. REGISTRAR'S SIGNATURE<br>Julia Davis                                                                                  |                                              |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 2 8 3 2 0  
REG. NO.

1- FOR STATE REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**Walter Jackson Ward**

2a DATE OF DEATH MONTH DAY YEAR  
**Oct. 13 1987**

2b HOUR M  
**AM**

3 SEX  
**Male**

4 RACE  
**White**

5. DATE OF BIRTH MONTH DAY YEAR  
**May 3 1918**

6 AGE (IN YEARS LAST BIRTHDAY) YRS  
**69**

IF UNDER 1 YEAR MONTHS DAYS  
IF UNDER 24 HRS. HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**Virginia**

7b CITIZEN OF WHAT COUNTRY?  
**USA**

8 MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH  
**Baltimore County** MD.

10 CITY OR TOWN OF DEATH  
**Maryland**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**Greater Balto. Med. Ctr.**

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**Structural Engr.**

12b KIND OF BUSINESS OR INDUSTRY  
**Engrg.**

13a STATE  
**Maryland**

13b COUNTY  
**Baltimore**

13c CITY OR TOWN  
**Lutherville**

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE  
**8405 Thornton Rd., 21093**

14 FATHER'S NAME FIRST MIDDLE LAST  
**Eugene Pendleton Ward**

15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Nellie Drayton Pangle**

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
**Yes**

16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)  
**WW II 212-07-0347**

17 INFORMANT ADDRESS  
**Mary E. Ward, same as 13e.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Carcinomatosis**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) **Malignant melanoma**

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
**2 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Coronary artery disease**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) this hospital attended the deceased from **4** 19 **64** to **10** 19 **87** that (1) we lost saw the deceased alive on **10/13** 19 **87**, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.

22b. SIGNATURE **Donald O. Wood, M.D.** DEGREE

22c. DATE SIGNED **10/13/87**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
**Donald O. Wood, M.D.**

22e. ADDRESS  
**York & Greenmeadow Drive, 21093**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**Burial**

23b. DATE  
**10/16/87**

23c. NAME OF CEMETERY OR CREMATORY  
**Dulaney Valley Mem. Gardens**

23d. LOCATION CITY OR TOWN COUNTY STATE  
**Timonium Balto. Md.**

24. FUNERAL DIRECTOR (TYPE OR PRINT)  
**J. E. Lowell Lemmon, 10 W. Padonia Rd.**

25a. DATE REC'D BY REGISTRAR  
**OCT 15 1987**

25b. REGISTRAR'S SIGNATURE  
*J. E. Lowell Lemmon*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been assigned by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1987

100 2 1 200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                   |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                 |  | REG. NO. 28321                                                                                                                     |  | 70215 OCT 29 87                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JAMES H. WARNER JR                                                                                                                                                                                                                                                               |  |                                                                                                                                    |  | 20. DATE OF DEATH MONTH DAY YEAR<br>10 19 87                                                                                                                |  | 2b. HOUR<br>1645 M                                                                                                                         |  |                                                                                                                            |  |
| 3. SEX<br>M                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>B 2                                                                                                                     |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>12 22 82                                                                                                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>4                                                                                                       |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                               |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                          |  |                                                                                                                            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD. 13b. COUNTY Baltimore                                                                                                                                                                                                   |  |                                                                                                                                    |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |  | 13e. STREET ADDRESS / ZIP CODE<br>9803 Charbank LA. 21220                                                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JAMES HENRY WARNER III                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ROSE LEE TAYLOR                                                                                               |  |                                                                                                                                            |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.                                                                                                           |  | 17. INFORMANT ADDRESS<br>JAMES H. WARNER 9803 Charbank LA                                                                                                   |  |                                                                                                                                            |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute status asthmaticus<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |  |                                                                                                                                            |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-22-82, 19 82, to 10-19-87, that (I) (we) last saw the deceased alive on 9-29-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (did) (did not) view the body after death.                             |  |                                                                                                                                    |  |                                                                                                                                                             |  |                                                                                                                                            |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>J. Crossan O'Donovan M.D.                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  | DEGREE<br>M.D.                                                                                                                                              |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/20/87                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. CROSSAN O'DONOVAN                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 22e. ADDRESS<br>2112 DUNDALK AVE, BALT., MD. 21222                                                                                                          |  |                                                                                                                                            |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>10-24-87                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hills Cemetery                                                                                                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore City MD.                                                                              |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR NAME<br>WM. E. BROWN                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  | ADDRESS<br>1206 W. North Ave                                                                                                                                |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1987                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                                                       |  |

BP

70512 OCT 1981

20% CATION CLAY

OCT 8 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

**IMPORTANT:** If Item 21 is marked or Item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                               |                                                 |                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                 |  | FIRST<br>Vernon                                                                                                           |  | MIDDLE<br>Oscar                                                                                                                                             |  | LAST<br>Warner                                                                                                                                       |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 5, 1987                                                                            |                                                 | 2b. HOUR<br>7:08 A.M.                                       |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>White                                                                                                          |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 3, 1912                                                                                                           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75<br>YRS                                                                                                         |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                |                                                 | IF UNDER 24 HOURS<br>HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Co. Md.                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.                                                                                            |  |                                                                                                                               |                                                 |                                                             |  |
| 10. CITY OR TOWN OF DEATH<br>Reisterstown                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN STATE FACILITY, GIVE STREET ADDRESS)<br>6 Wolf Ave. |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Schmidt                                                                  |  |                                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bakers Co. |                                                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                             |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                               |                                                 |                                                             |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                   |  | 13b. COUNTY<br>Balto.                                                                                                     |  | 13c. CITY OR TOWN<br>Reisterstown                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                 |  | 13e. STREET ADDRESS / ZIP CODE<br>6 Wolf Ave. 21136                                                                           |                                                 |                                                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Oliver Warner                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                           |  |                                                                                                                                                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Darcie Benson                                                                                       |  |                                                                                                                               |                                                 |                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                          |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-03-1306                                                    |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Dorothy B. Warner Reisterstown, Md.                                                                                        |  |                                                                                                                                                      |  |                                                                                                                               |                                                 |                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>EMPHYSEMA - CHF.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>HBP</u>                                                                                              |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                               |                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):                                                                                                                                                                                                                                          |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                               |                                                 |                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                          |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                 |                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)                                                                              |  |                                                                                                                                                      |  |                                                                                                                               |                                                 |                                                             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                                      |  |                                                                                                                               |                                                 |                                                             |  |
| 22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>19 82</u> , to <u>10/5</u> , 19 <u>87</u> , that (I) <u>was</u> last<br>saw the deceased alive on <u>3/18</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <u>was</u> <u>(did not)</u> view the body after death. |  |                                                                                                                           |  |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                                                                               |                                                 |                                                             |  |
| 22b. SIGNATURE<br><u>R. Ricci MD</u>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                           |  |                                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                                                                                                               | 22c. DATE SIGNED<br><u>10/5/87</u>              |                                                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>R. RICCI MD</u>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                           |  |                                                                                                                                                             |  | 22e. ADDRESS<br><u>3125 BALTO. BLVD. FINKSBURG, MD</u>                                                                                               |  |                                                                                                                               |                                                 |                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br>10/7/87                                                                                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.                                                                                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, Md.                                                                                        |  |                                                                                                                               |                                                 |                                                             |  |
| 24. FUNERAL DIRECTOR<br>Elite Funeral Home                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                           |  |                                                                                                                                                             |  | Reisterstown, Md. 21136                                                                                                                              |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 06 1987                                                                                  |                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u> |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                               |                                                                                                                                                             |                                                                                     |                                                                                                 |                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Dorothy WATSON</i>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10/24/87</i>                              |                                                                                                 | 2b. HOUR<br><i>3:05 PM</i>                             |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br><i>WHITE</i>                                                                                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8-23-1912</i>                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>75 YRS</i>                                    |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Washington D.C.</i>                                                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE COUNTY MD.</i>                 |                                                                                                 |                                                        |
| 10. CITY OR TOWN OF DEATH<br><i>GARRISON</i>                                                                                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS)<br><i>GARRISON VALLEY NURSING HOME</i> |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Waitress</i> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Restaurant</i> |
| 13a. STATE<br><i>MARYLAND</i>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                               | 13b. COUNTY<br><i>BALTIMORE</i>                                                                                                                             | 13c. CITY OR TOWN<br><i>GARRISON</i>                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>CHARLES FRANCES BURKETT</i>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                               | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><i>M. CHRISTOPHER</i>                                                                                            |                                                                                     | 16. STREET ADDRESS / ZIP CODE<br><i>9600 REISTERSTOWN ROAD 21055</i>                            |                                                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                               | 16b. SOCIAL SECURITY NO.<br><i>218-05-7885</i>                                                                                                              |                                                                                     | 17. INFORMANT<br>ADDRESS<br><i>Jack Burkett 1011 Sharon Drive Glen Burnie, Md. 21061</i>        |                                                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>SEPSIS</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>PNEUMONIA</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>ORGANIC BRAIN SYNDROME / SEIZURE DISORDER / Accidental Ute</i> |                                                                                                                                                               |                                                                                                                                                             |                                                                                     |                                                                                                 |                                                        |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                        |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                                                                                                                             |                                                                                     |                                                                                                 |                                                        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                               |                                                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>3:05 (P.M.) 10-24-1987</i>                                                                            |                                                                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                                                        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |                                                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                     | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |                                                        |
| 22a. certify that (I) (this hospital) attended the deceased from <i>9/26/87</i> 19 <i>87</i> , to <i>10-24-</i> 19 <i>87</i> , that (I) (we) lost<br>saw the deceased alive on <i>10-24-</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death.                                                                                |                                                                                                                                                               |                                                                                                                                                             |                                                                                     |                                                                                                 |                                                        |
| 22b. SIGNATURE<br><i>Mohammed Aslam M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                               | DEGREE<br><i>M.D.</i>                                                                                                                                       |                                                                                     | 22c. DATE SIGNED<br><i>10/25/87</i>                                                             |                                                        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MOHAMMAD ASLAM-MD</i>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                               | 22e. ADDRESS<br><i>300-ARMORY PLACE BALT. MD</i>                                                                                                            |                                                                                     |                                                                                                 |                                                        |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                               | 23b. DATE<br><i>10/28/87</i>                                                                                                                                |                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Crestlawn Cemetery</i>                                 |                                                        |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Marriottsville Md.</i>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                               |                                                                                                                                                             |                                                                                     |                                                                                                 |                                                        |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>1630 Edmondson Ave. Catonsville, Md. 21228</i><br><i>Leroy M. &amp; Russell C. Witzke Funeral Home</i>                                                                                                                                                                                                                                                                                                      |                                                                                                                                                               |                                                                                                                                                             |                                                                                     | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 26 1987</i>                                             |                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                               |                                                                                                                                                             |                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rudolph</i>                                     |                                                        |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This detachable page must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                               |                                                                               |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <u>Ruth</u> MIDDLE <u>Jameson</u> LAST <u>Watson</u>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                               | 2a. DATE OF DEATH MONTH DAY YEAR<br><u>10-9-87</u>                            |                                                                                                                                                             |                                                                                | 2b. HOUR<br><u>1:10 P</u> <sup>M</sup>                                               |                                                                                                 |                                                                                                                            |                                                                |  |
| 3. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><u>White</u>                                                                                                       |                                                                               | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>Sept. 22- 1895</u>                                                                                                 |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>92</u> YRS                                     |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                                            |                                                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maine</u>                                                                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                    |                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore County</u> MD.                  |                                                                                                 |                                                                                                                            |                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><u>Cockeysville</u>                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Broadmead</u> |                                                                               |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Housewife</u> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Homemaker</u>                                                                      |                                                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>Maryland</u>                                                                                                                                                                                                                                                                                        |  |                                                                                                                               | 13b. COUNTY<br><u>Baltimore</u>                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br><u>Cockeysville</u>                                       |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br><u>13801 York Road 21030</u> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Harry Preston Jameson</u>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                               |                                                                               |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Rose Wedgwood</u>          |                                                                                      |                                                                                                 |                                                                                                                            |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                               | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>007-44-5678</u> |                                                                                                                                                             | 17. INFORMANT ADDRESS<br><u>Richard D. Watson 2800 Lehigh Rd. 17402</u>        |                                                                                      |                                                                                                 |                                                                                                                            |                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Respiratory Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Intraabdominal Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Esophagitis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                                               |                                                                               |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>months</u>                                            |                                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Esophagitis</u>                                                                                                                                                                                                                                                             |  |                                                                                                                               |                                                                               |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                                |  |
| 19a. DATE OF OPERATION<br><u>June 5, 1987</u>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Esophagitis</u>        |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                           |  |                                                                                                                               | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |                                                                                      |                                                                                                 |                                                                                                                            |                                                                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                               | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                      |                                                                                                 |                                                                                                                            |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1987</u> to <u>Oct 9, 1987</u> , that (I) (we) lost soul the deceased alive on <u>Oct 9, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                      |  |                                                                                                                               |                                                                               |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                                |  |
| 22b. SIGNATURE<br><u>Susan M. Long MD</u>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                               |                                                                               |                                                                                                                                                             | DEGREE<br><u>MD</u>                                                            |                                                                                      | 22c. DATE SIGNED<br><u>10-9-87</u>                                                              |                                                                                                                            |                                                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Susan M. Long MD</u>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                               |                                                                               |                                                                                                                                                             | 22e. ADDRESS<br><u>13801 York Road</u>                                         |                                                                                      |                                                                                                 |                                                                                                                            |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                               | 23b. DATE<br><u>10-12-87</u>                                                  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Riverside Cemetery</u>                |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Orono Maine</u>                                |                                                                                                                            |                                                                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Martin D. Lawson</u>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                               |                                                                               |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 13 1987</u>                            |                                                                                      |                                                                                                 |                                                                                                                            |                                                                |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson</u>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                               |                                                                               |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                            |                                                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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Postcard

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                 |                                                        |                                                                                                                                                             |  |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Kathleen Lee Waugh                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 10 1987 |                                                                                                                                                             |  | 2b. HOUR<br>M                                                                                                              |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br>White                                                                                                                                                                                                                                                                                                                                                                                |                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 14 1939                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>47                                                                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Conn.                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                             |                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                               |  |
| 10. CITY OR TOWN OF DEATH<br>Essex                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2 Mars Road                                                                                                                                                                                                                                                                        |                                                        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY<br>Balto.                                                                                                                                                                                                                                                                                                                                                                           |                                                        | 13c. CITY OR TOWN<br>Essex                                                                                                                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Lee Frye                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Lucille Jerolimo                                                                                                                                                                                                                                                                                                                          |                                                        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-36-6879                                                     |  |
| 17. INFORMANT<br>ADDRESS<br>Samuel Edward Waugh 2 Mars Road 21221                                                                                                                                                                                                                                                           |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                                                                                                                                                                                                                                                                |                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                                                                                                                                                                                                                                                      |                                                        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                                                                                                                                                                                                                                                          |                                                        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                                                                                                                                                                                                                                                                                 |                                                        |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>[Signature]</u> DEGREE                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                 |                                                        | 22c. DATE SIGNED                                                                                                                                            |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BA YINOUNS                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                 |                                                        | 22e. ADDRESS<br>8022 BELAIR ROAD<br>BALTO., MD. 21236                                                                                                       |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                   |  | 23b. DATE<br>10/12/87                                                                                                                                                                                                                                                                                                                                                                           |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process Inc.                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                                           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Connelly Funeral Home 300 Mace Ave. 21221                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                 |                                                        | 25a. DATE REC'D. BY REGISTRAR<br>OCT 13 1987                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                           |  |

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ADOLPHUS LIBRARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

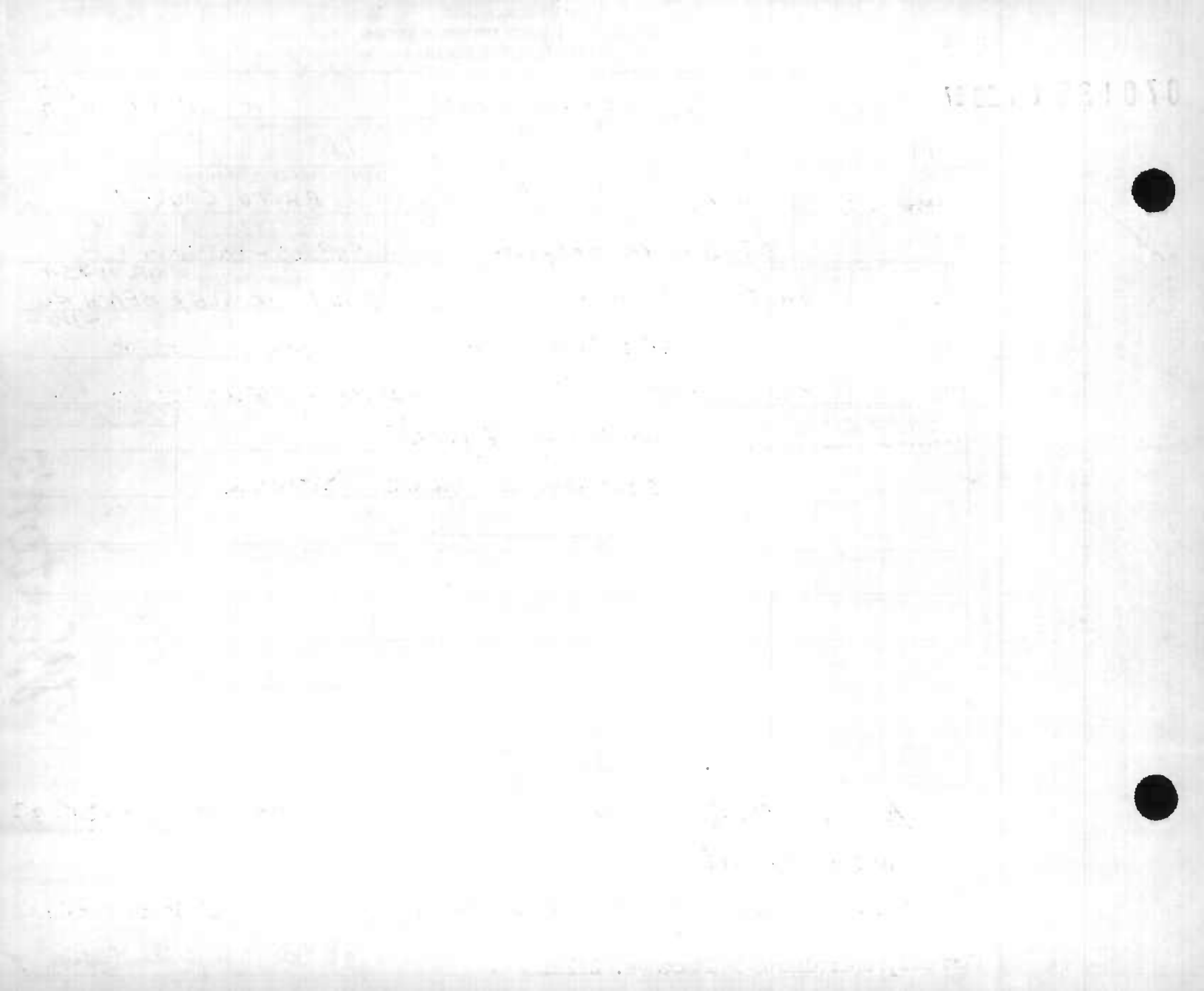
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Explain that 2 this lid be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                               |                                                                                                     |                                                                         |                                                                                                                            |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | REG. NO.                                                                      |                                                                                                     |                                                                         |                                                                                                                            |                                              |
| 1. DECEASED NAME<br>(PRINT) <b>JOHN R WEATHERSTEIN</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 25 87</b>                        |                                                                                                     |                                                                         | 2b. HOUR<br><b>10 15 A.M.</b>                                                                                              |                                              |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>W</b>                                                                                                                     |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 06 14</b>                                                                                                        |                                                                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>                                                        |                                                                         | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                          |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD Maryland</b>                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                            |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO COUNTY</b> MD.                                     |                                                                         |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |                                                                        |                                                                                                                                                             |                                                                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired - Baltimore City</b> |                                                                         | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                          |                                              |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>BALTO</b>                                                                                                             |                                                                        | 13c. CITY OR TOWN<br><b>White Marsh</b>                                                                                                                     |                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |                                                                         | 13e. STREET ADDRESS / ZIP CODE<br><b>5927 LORELEY BEACH RD WHITE MARSH 21162</b>                                           |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Weatherstein</b>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Rose Lochner</b>                                                                                   |                                                                               |                                                                                                     |                                                                         |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 218-10-5756</b>                                                      |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Stella Weatherstein 5927 Loreley Beach Road</b>                                                                              |                                                                               |                                                                                                     |                                                                         |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Ischaemic heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                               |                                                                                                     |                                                                         |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                                                            |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                               |                                                                                                     |                                                                         |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |                                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                      |  |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                                                                                                     |                                                                         |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                     |  |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                                                                                     |                                                                         |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                      |  |                                                                                                                                         |                                                                        |                                                                                                                                                             |                                                                               |                                                                                                     |                                                                         |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>Hussie Slag</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | DEGREE                                                                        |                                                                                                     | 22c. DATE SIGNED<br><b>10.25.87</b>                                     |                                                                                                                            |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MDKH ZOUNI</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 22e. ADDRESS                                                                  |                                                                                                     |                                                                         |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                         | 23b. DATE<br><b>10/28/87</b>                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus</b>            |                                                                                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Connelly Funeral Home 300 Mace Ave. 21221</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                         |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1987</b>                           |                                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Swinton-Randall</b>              |                                                                                                                            |                                              |

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

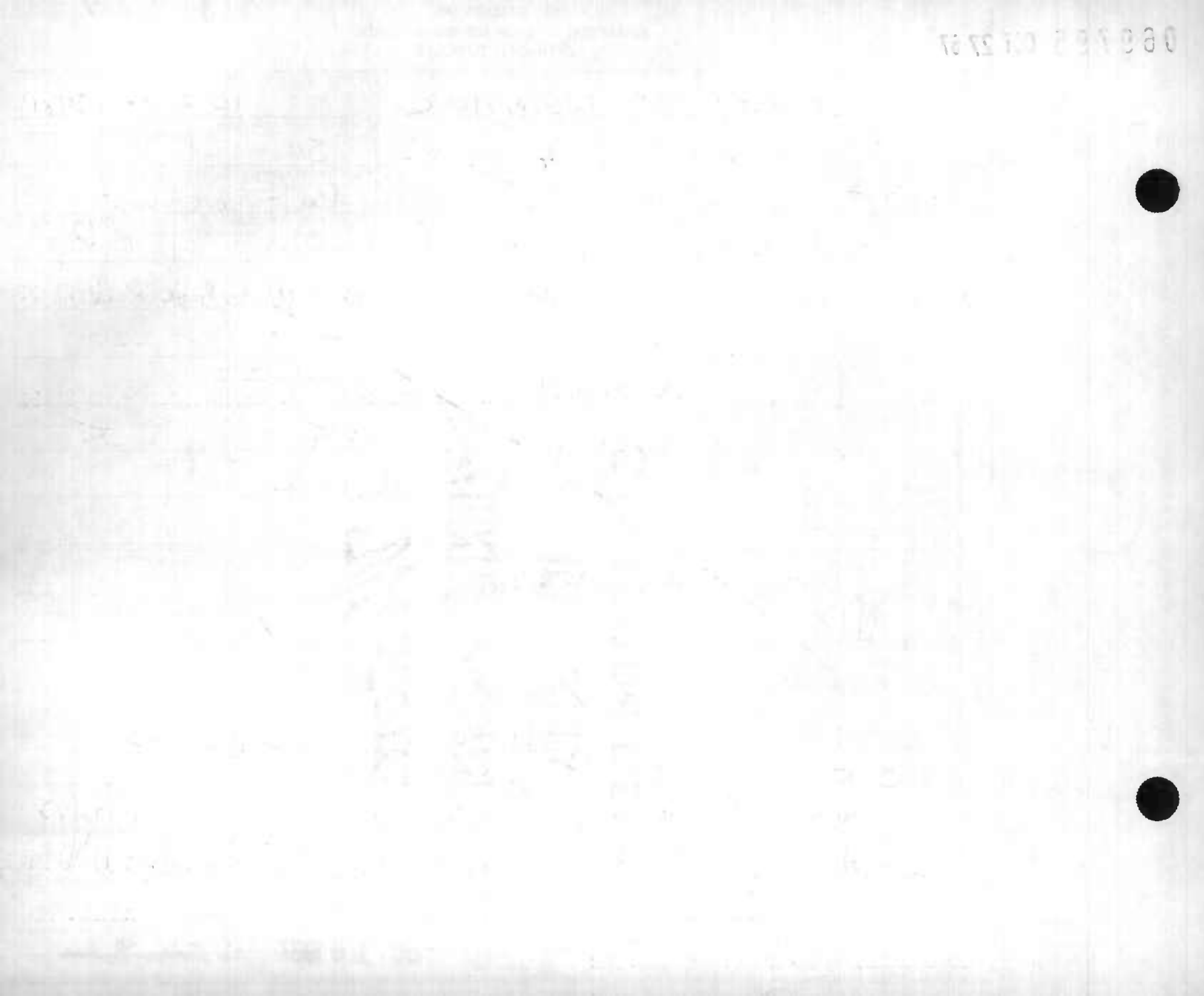
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH-16 50M 1/B1  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |                                                                                     |                                                                                                                                                  |                                          |                                                                                                            |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SHIRLEY RUTH WEINSTOCK</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>20</b> YEAR <b>87</b>                   |                                                                                                                                                  |                                          | 2b. HOUR<br><b>3:48 PM</b>                                                                                 |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>WHITE</b>                                                                                                                      |                                                                                     | 5. DATE OF BIRTH<br>MONTH <b>04</b> DAY <b>29</b> YEAR <b>37</b>                                                                                 |                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>50</b> YRS                                                           |                                                                                      | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>                                                               |                                                                             |                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                   |                                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                                         |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General</b> |                                                                                     |                                                                                                                                                  |                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                       |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                                                                        |                                                                             |                                     |  |
| 13a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              | 13b. COUNTY<br><b>Baltimore</b>                                                     |                                                                                                                                                  | 13c. CITY OR TOWN<br><b>Randallstown</b> |                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                            | 13e. STREET ADDRESS<br><b>8827 Winter Brook Road</b> 21133                  |                                     |  |
| 14. FATHER'S NAME<br>FIRST <b>EMANUEL</b> MIDDLE <b>BERNSTEIN</b> LAST <b></b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |                                                                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>JEAN</b> MIDDLE <b>WEINER</b> LAST <b>ACKMAN</b>                                                            |                                          |                                                                                                            |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>26 3+5824</b>                                                                                                     |                                          | 17. INFORMANT<br>ADDRESS<br><b>WILLIAM WEINSTOCK</b><br><b>8827 WINTERBROOK RD. RANDALLSTOWN, MD 21133</b> |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial ischemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                              |                                                                                     |                                                                                                                                                  |                                          |                                                                                                            |                                                                                      |                                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>mins</b>                 |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>AWD Diabetes mellitus</b>                                                                                                                                                                                                              |  |                                                                                                                                              |                                                                                     |                                                                                                                                                  |                                          |                                                                                                            |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>                         |                                                                                                                                                  |                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |                                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                                                             |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                        |  |                                                                                                                                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11:45 10 20 87</b>            |                                                                                                                                                  |                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NA</b>                |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                       |  |                                                                                                                                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>NA</b> |                                                                                                                                                  |                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>NA</b>                                             |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>10:20</b> 19 <b>87</b> , to <b>10:20</b> 19 <b>87</b> , that (we) lost saw the deceased alive on <b>10:20</b> 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we did) (did not) view the body after death.                                |  |                                                                                                                                              |                                                                                     |                                                                                                                                                  |                                          |                                                                                                            |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
| 22b. SIGNATURE<br><b>Dr. Hester Copeland</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |                                                                                     |                                                                                                                                                  |                                          | DEGREE<br><b>MD</b>                                                                                        |                                                                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                             | 22c. DATE SIGNED<br><b>10/20/87</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Hester Copeland</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |                                                                                     |                                                                                                                                                  |                                          | 22e. ADDRESS<br><b>8620 Lister Park Rd Randallstown MD 21133</b>                                           |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              | 23b. DATE<br><b>OCT. 22, 1987</b>                                                   |                                                                                                                                                  |                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE HEBREW</b>                                              |                                                                                      |                                                                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>REISTERSTOWN BALTO. MD</b> |                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD</b>                                                                                                                                                                                                                                                              |  |                                                                                                                                              |                                                                                     |                                                                                                                                                  |                                          | 25. DATE REC'D BY REGISTRAR<br><b>OCT 26 1987</b>                                                          |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |                                                                                     |                                                                                                                                                  |                                          | 25b. REGISTRAR'S SIGNATURE<br><b>Jane Decker-Rudner</b>                                                    |                                                                                      |                                                                                                                                            |                                                                             |                                     |  |



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 2 8 3 2 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 2. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BOLOMON WEIS</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                 | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCT. 25, 87</b>              |                                                                                                                                                             |                                                                                           | 2b. HOUR<br><b>8:10 A</b><br>M                                                                                                                       |                                                                                                 |                                                                                                                            |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>Cauc.</b>                                                                                                                         |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 17, 1900</b>                                                                                                 |                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b><br>YRS                                                                                                  |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.                                                           |                                              |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>LITHUANIA</b>                                                                                                                                                                                                                                                                                                                                     |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                      |                                                                        | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CO. MD.</b>                                                                                     |                                                                                                 |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |                                                                        |                                                                                                                                                             |                                                                                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TAILOR</b>                                                                    |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CLOTHES</b>                                                                        |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 | 13b. COUNTY<br><b>BALTO.</b>                                           |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTO.</b>                                                        |                                                                                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                            |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ABRAHAM WEIS</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORA JACOBS</b>    |                                                                                                                                                             |                                                                                           | 16. STREET ADDRESS / ZIP CODE<br><b>6400 ELRAY DR., APT. D 21209</b>                                                                                 |                                                                                                 |                                                                                                                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                 | 16b. SOCIAL SECURITY NO.<br><b>216-03-1780</b>                         |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>MRS. MINNIE WEIS APT. D 6400 ELRAY DR. BALTO. MD 21209</b> |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of the prostate with</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastasis</b> |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                 |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                         |  |                                                                                                                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                         |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT. 9, 1987</b> to <b>OCT. 25, 1987</b> , that (I) (we) last saw the deceased alive on <b>OCT. 25, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                    |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>Sharon Pourmotabed, M.D.</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                           | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>10-25-87</b>                                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GHASSEM POURMOTABED</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                           | 22e. ADDRESS<br><b>Balto. Co. General Hospital</b>                                                                                                   |                                                                                                 |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 | 23b. DATE<br><b>OCT. 26, 1987</b>                                      |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MIKRO KODESH-BETH ISRAEL BALTO.</b>              |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MARYLAND</b>                            |                                                                                                                            |                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS. INC.</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                           | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>OCT 30 1987 Julia Davidson-Pedersen</b>                                                |                                                                                                 |                                                                                                                            |                                              |
| 6010 REISTERSTOWN RD. BALTO. MD 21215                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 |                                                                        |                                                                                                                                                             |                                                                                           |                                                                                                                                                      |                                                                                                 |                                                                                                                            |                                              |

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DDM

OCT 30 1987

69260 OCT 21 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 28329

REG. NO.

FOR  
1- STATE  
REGISTRAR

|                                                                                                                   |  |                                                                                                                                            |  |                                                                                                                                                             |  |                                                                             |  |                                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Sister Mary Celine Weissenberger                                           |  |                                                                                                                                            |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 16 87                                                                                                             |  |                                                                             |  | 2b. HOUR<br>6:35 PM                                                                             |  |
| 3. SEX<br>Female                                                                                                  |  | 4. RACE<br>White                                                                                                                           |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 5 07                                                                                                               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Louisville Ky                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                 |  |                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Villa 6806 Bellona Ave. |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. |  |                                                                                                                                            |  | 13b. COUNTY<br>Balto.                                                                                                                                       |  | 13c. CITY OR TOWN<br>Balto.                                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles A. Weissenberger                                                |  |                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ayleen Clements                                                                                            |  |                                                                             |  |                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                        |  |                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220 54 8382                                                                                      |  | 17. INFORMANT<br>ADDRESS<br>Sr. M. Gonzaga 6806 Bellona Ave.                |  |                                                                                                 |  |

|                                                                                                                                                                                                                                                                                                                      |  |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Coronary artery disease with mitral valve and aortic regurgitation                                                                                                                                                                                                                                                   |  |                                              |  |
| Chronic obstructive pulmonary disease                                                                                                                                                                                                                                                                                |  |                                              |  |
| Peripheral vascular disease                                                                                                                                                                                                                                                                                          |  |                                              |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|                                                                                                                                                       |  |                                                                        |  |                                                                                |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 19a. DATE OF OPERATION                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                             |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                                            |  |

|                                                                                                                                                                                                                                                                                                                          |  |  |                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------|
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. |  |  |                                                      |
| 22b. SIGNATURE<br>Pratima Bose M.D.                                                                                                                                                                                                                                                                                      |  |  | 22c. DATE SIGNED<br>10/17/87                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PRATIMA BOSE M.D.                                                                                                                                                                                                                                                               |  |  | 22e. ADDRESS<br>301 St Paul Place Baltimore MD 21202 |

|                                                     |  |                       |  |                                                |  |                                                                           |  |
|-----------------------------------------------------|--|-----------------------|--|------------------------------------------------|--|---------------------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial |  | 23b. DATE<br>10-19-87 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Baltimore Maryland |  |
|-----------------------------------------------------|--|-----------------------|--|------------------------------------------------|--|---------------------------------------------------------------------------|--|

|                                                                              |  |                                              |  |                                            |  |
|------------------------------------------------------------------------------|--|----------------------------------------------|--|--------------------------------------------|--|
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home 6500 York Road 21212 |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1987 |  | 25b. REGISTRAR'S SIGNATURE<br>Julia T. ... |  |
|------------------------------------------------------------------------------|--|----------------------------------------------|--|--------------------------------------------|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



|                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |                                                                |                                                                                                                                                             |  |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Martin Gerard Weitzel Sr.</i>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>October 17, 1987</i> |                                                                                                                                                             |  | 2b. HOUR<br>A. M.<br><i>A. M.</i>                                                                                          |  |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><i>White</i>                                                                                                                   |                                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 20 23</i>                                                                                                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>63</i>                                                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                             |                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                                                        |  |
| 10. CITY OR TOWN OF DEATH<br><i>Rossville</i>                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Franklin Square Hospital</i> |                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>                                                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Internal Reven.</i>                                                                |  |
| 13a. STATE<br><i>Md.</i>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><i>Baltimore</i>                                                                                                           |                                                                | 13c. CITY OR TOWN<br><i>Rosedale</i>                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William Weitzel</i>                                                                                                                                                                                                                                                                                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Dorothy Flury</i>                                                                     |                                                                | 13e. STREET ADDRESS / ZIP CODE<br><i>8110 Sagamore Road 21237</i>                                                                                           |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>W.W. 2 216-16-2905</i>                                                      |                                                                | 17. INFORMANT ADDRESS<br><i>Louise C. Weitzel 8110 Sagamore Rd. 21237</i>                                                                                   |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>acute MI</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>coronary disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>hrs 74</i> |  |                                                                                                                                           |                                                                |                                                                                                                                                             |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><i>Ca prostate</i>                                                                                                                                                                                                                                                                      |  |                                                                                                                                           |                                                                |                                                                                                                                                             |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 10 19 87</i>                                                                   |                                                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                              |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                    |                                                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-30</i> 19 <i>87</i> to <i>10-17</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>10-17</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                  |  |                                                                                                                                           |                                                                |                                                                                                                                                             |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><i>Michael T. Rudikoff</i>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |                                                                | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><i>10/19/87</i>                                                                                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Michael T. Rudikoff MD</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                           |                                                                | 22e. ADDRESS<br><i>222 W. Cold Spring Lane 21210</i>                                                                                                        |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><i>10-20-87</i>                                                                                                              |                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn Cemetery</i>                                                                                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Eastwood, Balto. Co., Md.</i>                                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles S. Zeiler &amp; Son Inc.</i>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                           |                                                                | ADDRESS<br><i>6224 Eastern Ave.</i>                                                                                                                         |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 19 1987</i>                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |                                                                | 25b. REGISTRAR'S SIGNATURE<br><i>John Burton</i>                                                                                                            |  |                                                                                                                            |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 48 shows any injury or other traumatic event, the medical examiner must be notified of page 3.

BP. \_\_\_\_\_

DHMH - 16 60M 7/B4  
(VRA 15, 4)







069006 OCT 20 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                    |  | FIRST MIDDLE LAST                                                                                      |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                         |  | 2b. HOUR                                                            |  |
| Dorothy                                                                                                                                                                                                                                                                                                                                                                                                                                |  | C. WELLS                                                                                               |  | October 15, 1987                                                                                                                                         |  | 9:15a M                                                             |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                                                                                          |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| FEMALE                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | WHITE                                                                                                  |  | JAN. 15 1917                                                                                                                                             |  | 70                                                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | U.S.A.                                                                                                 |  |                                                                                                                                                          |  | Baltimore County MD.                                                |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                                                                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                                                              |  | FRANKLIN SQUARE HOSPITAL                                                                               |  | HOMEMAKER                                                                                                                                                |  | -                                                                   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY                                                                                            |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS?                                            |  |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | BALTIMORE                                                                                              |  | BALTIMORE                                                                                                                                                |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                             |  | 13e. STREET ADDRESS / ZIP CODE                                                                                                                           |  |                                                                     |  |
| SCOTT PRESTON                                                                                                                                                                                                                                                                                                                                                                                                                          |  | MADELINE BOWEN                                                                                         |  | 2009 LONGVIEW AVE. 21237                                                                                                                                 |  |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                                                                      |  | 16b. SOCIAL SECURITY NO.                                                                               |  | 17. INFORMANT ADDRESS                                                                                                                                    |  |                                                                     |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 216-28-5209A                                                                                           |  | WILLIAM C. WELLS (SON) 8504 KINGS RIDGE RD. 21234                                                                                                        |  |                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Hypoxemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Lung cancer</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)                                                                                                                                                                                                                                                                                                   |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                           |  |                                                                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                     |  |
| 22a. I certify that (this hospital) attended the deceased from <u>October 9</u> , 19 <u>87</u> , to <u>October 15</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>October 15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.                                                                |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                     |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                         |  | DEGREE                                                                                                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED                                                    |  |
| <u>Michael A. Fullop</u>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                                                                                                          |  | 10/15/87                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS                                                                                           |  |                                                                                                                                                          |  |                                                                     |  |
| Michael Fullop, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 9000 Franklin Square Dr., Balto., 21237                                                                |  |                                                                                                                                                          |  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10/19/87                                                                                               |  | OAK LAWN                                                                                                                                                 |  | BALTIMORE M.D.                                                      |  |
| 24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                            |  | 25b. REGISTRAR'S SIGNATURE                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |  | OCT 16 1987                                                                                                                                              |  | <u>John Davidson-Randall</u>                                        |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages only 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the carbon paper pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |  |                                                                                                                                                             |                                                       |                                                                                              |                            |                                                                                                                         |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1- FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                           |  |                                                                                                                                                             |                                                       |                                                                                              |                            |                                                                                                                         |                                              |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>RICHARD Russell WHIPPO</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |  |                                                                                                                                                             | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 21 1987</b> |                                                                                              | 2b. HOUR<br><b>7:55 PM</b> |                                                                                                                         |                                              |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>White</b>                                                                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>04 17 '16</b>                                                                                                         |                                                       | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>71</b>                                             |                            | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>                                                                |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                          |                            |                                                                                                                         |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |                                                                                                                                                             |                                                       | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>              |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>                                                                   |                                              |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                                           |  | 13c. CITY OR TOWN<br><b>Reisterstown</b>                                                                                                                    |                                                       | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            | 13e. STREET ADDRESS / ZIP CODE<br><b>27 Chestnut Hill Lane, 21136</b>                                                   |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Russell Whippo</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elda Jane Alexander</b>                                                                                    |                                                       |                                                                                              |                            |                                                                                                                         |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>                                                                      |  | 17. INFORMANT<br><b>Virginia E. Whippo</b>                                                                                                                  |                                                       | ADDRESS<br><b>27 Chestnut Hill Ln. 21136</b>                                                 |                            |                                                                                                                         |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>INTRACRANIAL HEMORRHAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>DISSEMINATED INTRAVASCULAR COAGULATION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE LEUKEMIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>4 HRS.</b><br><b>4 DAYS</b><br><b>4 DAYS</b> |  |                                                                                                                                           |  |                                                                                                                                                             |                                                       |                                                                                              |                            |                                                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                           |  |                                                                                                                                                             |                                                       |                                                                                              |                            |                                                                                                                         |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                          |  |                                                                                                                                                             |                                                       | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                              |                                                       |                                                                                              |                            |                                                                                                                         |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                       |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                                                                                              |                                                       |                                                                                              |                            |                                                                                                                         |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> , 19 <b>87</b> , to <b>10/21</b> , 19 <b>87</b> , that (I) (we) lost the deceased alive on <b>10/21</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                 |  |                                                                                                                                           |  |                                                                                                                                                             |                                                       |                                                                                              |                            |                                                                                                                         |                                              |
| 22b. SIGNATURE<br><b>Charles Padgett</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                           |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                       |                                                                                              |                            | 22c. DATE SIGNED<br><b>10/21/87</b>                                                                                     |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. PADGETT, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                           |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST.</b>                                                                                                             |                                                       |                                                                                              |                            |                                                                                                                         |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>10/26/87</b>                                                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. Gardens</b>                                                                                    |                                                       | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Timonium Balto. Md.</b>                        |                            |                                                                                                                         |                                              |
| 24. FUNERAL DIRECTOR NAME<br><b>Martin D. Lawson</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                           |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 26 1987</b>                                                                                                         |                                                       | 25b. REGISTRAR'S SIGNATURE<br><b>John E. ...</b>                                             |                            |                                                                                                                         |                                              |

MEDICAL CERTIFICATION

REPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000000000000

DATE

THIRD

THIRD

BY THE

BALTIMORE COUNTY

SECOND-STORY N. CHARLES ST.

THIRD

12

2 PRS.

INTERMEDIATE MESSAGE

THIS MESSAGE IS BEING TRANSMITTED BY

11 DAYS

FOUR LETTERS

X

27

10/12

27

10/12

SECOND-STORY N. CHARLES ST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove copy to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                   |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                |  |                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|--|-------------------------------------------------------|--|
| DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                |  |                                                                                                        | FIRST MIDDLE LAST |                                                                                                                                                             |  | 2a. DATE OF DEATH MONTH DAY YEAR                                                                                                                     |  |                                                                |  | 2b. HOUR                                              |  |
| Pearle P. Wilbourn                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        |                   |                                                                                                                                                             |  | October 15, 1987                                                                                                                                     |  |                                                                |  | M                                                     |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE                                                                                                |                   | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                                                                                      |  | IF UNDER 1 YEAR                                                |  | IF UNDER 24 HRS.                                      |  |
| F                                                                                                                                                                                                                                                                                                                                               |  | W                                                                                                      |                   | Aug. 24, 1899                                                                                                                                               |  | 88 YRS                                                                                                                                               |  | MONTHS DAYS                                                    |  | HOURS MIN.                                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                           |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                                                                                 |  |                                                                |  |                                                       |  |
| Md.                                                                                                                                                                                                                                                                                                                                             |  | USA                                                                                                    |                   |                                                                                                                                                             |  | Baltimore Co., MD.                                                                                                                                   |  |                                                                |  |                                                       |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |                                                                                                                                                             |  |                                                                                                                                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |
| Towson                                                                                                                                                                                                                                                                                                                                          |  | Presbyterian Home of Maryland                                                                          |                   |                                                                                                                                                             |  |                                                                                                                                                      |  | Teacher                                                        |  | Schools                                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                    |  | 13b. STATE                                                                                             |                   | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS?                                                                                                                             |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |                                                       |  |
| Md.                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |                   | Baltimore                                                                                                                                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                  |  | 3811 Canterbury Rd. 21218                                      |  |                                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |                   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                                                                  |  |                                                                                                                                                      |  |                                                                |  |                                                       |  |
| Royal Lee Phelps                                                                                                                                                                                                                                                                                                                                |  |                                                                                                        |                   | Lillie M. Swift                                                                                                                                             |  |                                                                                                                                                      |  |                                                                |  |                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.                                                                               |                   | 17. INFORMANT                                                                                                                                               |  | ADDRESS                                                                                                                                              |  |                                                                |  |                                                       |  |
| No                                                                                                                                                                                                                                                                                                                                              |  | 216 07 9837                                                                                            |                   | Presbyterian Home of Maryland                                                                                                                               |  | Towson, Md.                                                                                                                                          |  |                                                                |  |                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) - ASCVD & CHF -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                        |                   |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>weeks |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>- Recent CVA -                                                                                                                                                                                          |  |                                                                                                        |                   |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                |  |                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                   |                                                                                                                                                             |  | 20a. AUTOPSY?                                                                                                                                        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                        |                   |                                                                                                                                                             |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                             |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |  |                                                                                                                                                      |  |                                                                |  |                                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                     |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |  |                                                                                                                                                      |  |                                                                |  |                                                       |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 12-11-1975, to 10-15-1987, that (I) (we) last saw the deceased alive on 10-14-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                        |  |                                                                                                        |                   |                                                                                                                                                             |  |                                                                                                                                                      |  |                                                                |  |                                                       |  |
| 22b. SIGNATURE<br>S. J. VENABLE JR MD                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |                   |                                                                                                                                                             |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10-16-87                                   |  |                                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |                   |                                                                                                                                                             |  | 22e. ADDRESS                                                                                                                                         |  |                                                                |  |                                                       |  |
| S. J. VENABLE JR MD                                                                                                                                                                                                                                                                                                                             |  |                                                                                                        |                   |                                                                                                                                                             |  | 7215 YORK RD - BALTIMORE MD 21212                                                                                                                    |  |                                                                |  |                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                                                                                                       |  | 23b. DATE                                                                                              |                   | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION                                                                                                                                        |  | CITY OR TOWN COUNTY STATE                                      |  |                                                       |  |
| Burial                                                                                                                                                                                                                                                                                                                                          |  | 10/19/87                                                                                               |                   | Parkwood Cemetery                                                                                                                                           |  | Baltimore, Md.                                                                                                                                       |  |                                                                |  |                                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                            |  |                                                                                                        |                   |                                                                                                                                                             |  | 25a. DATE REC'D. BY REGISTRAR                                                                                                                        |  | 25b. REGISTRAR'S SIGNATURE                                     |  |                                                       |  |
| MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.                                                                                                                                                                                                                                                                                                     |  |                                                                                                        |                   |                                                                                                                                                             |  | OCT 20 1987                                                                                                                                          |  | Julia Swinson-Randall                                          |  |                                                       |  |

BP

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052 OCT -8 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                             |  |                          |                                                                                                                                           |                                                                      |                                                                         |                                                                                                                                                             |                                                                                            |                                                                   |                                                              | REG. NO.                                                                                                                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Paul E. Wiles</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                          |                                                                                                                                           |                                                                      |                                                                         |                                                                                                                                                             |                                                                                            |                                                                   |                                                              | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 10 4 1987 |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE<br>White         |                                                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar 2 1927                     |                                                                         | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>60 YRS.                                                                                                               |                                                                                            | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                       |                                                              | 2b. HOUR<br>6:40 PM                                                                                                                                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                               |  |                          | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                       |                                                                      |                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                            |                                                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD. |                                                                                                                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                                                                                                                                                           |  |                          | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County Gen. Hosp. |                                                                      |                                                                         |                                                                                                                                                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired- Sheet Metal Work |                                                                   |                                                              | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                               |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                                                          |  |                          |                                                                                                                                           |                                                                      |                                                                         |                                                                                                                                                             |                                                                                            |                                                                   |                                                              |                                                                                                                                                                 |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br>Baltimore |                                                                                                                                           | 13c. CITY OR TOWN<br>Reisterstown                                    |                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                                                                                            | 13e. STREET ADDRESS<br>205 Mysticwood Rd. 21136                   |                                                              |                                                                                                                                                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elmer E. Wiles                                                                                                                                                                                                                                                                                                                                                                                            |  |                          |                                                                                                                                           |                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mildred A. Trieschmann |                                                                                                                                                             |                                                                                            |                                                                   |                                                              |                                                                                                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                                                                                        |  |                          |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1945-1946 |                                                                         | 17. INFORMANT<br>Dorothy E. Sheffield                                                                                                                       |                                                                                            |                                                                   | ADDRESS<br>SAA                                               |                                                                                                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>DIABETES Mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                        |  |                          |                                                                                                                                           |                                                                      |                                                                         |                                                                                                                                                             |                                                                                            |                                                                   |                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                                 |  |                          |                                                                                                                                           |                                                                      |                                                                         |                                                                                                                                                             |                                                                                            |                                                                   |                                                              |                                                                                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                          |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                    |                                                                         |                                                                                                                                                             |                                                                                            |                                                                   |                                                              | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                        |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                              |  |                          |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19           |                                                                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                                                                               |                                                                                            |                                                                   |                                                              |                                                                                                                                                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                      |  |                          |                                                                                                                                           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)          |                                                                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                           |                                                                                            |                                                                   |                                                              |                                                                                                                                                                 |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                          |                                                                                                                                           |                                                                      |                                                                         |                                                                                                                                                             |                                                                                            |                                                                   |                                                              |                                                                                                                                                                 |  |
| ACTUAL SIGNATURE<br><i>E.P. Williams</i>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                          |                                                                                                                                           |                                                                      |                                                                         | TITLE (SPECIFY)<br>Medical Examiner                                                                                                                         |                                                                                            |                                                                   | DATE SIGNED<br>10/4/87                                       |                                                                                                                                                                 |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>E.P. Williams                                                                                                                                                                                                                                                                                                                                                                                                 |  |                          |                                                                                                                                           |                                                                      |                                                                         | ADDRESS<br>5550 BALTIMORE AVE LK 21228                                                                                                                      |                                                                                            |                                                                   |                                                              |                                                                                                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                              |  |                          | 23b. DATE<br>10-8-87                                                                                                                      |                                                                      | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Park             |                                                                                                                                                             |                                                                                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Md. |                                                              |                                                                                                                                                                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Eline Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                  |  |                          |                                                                                                                                           |                                                                      |                                                                         | ADDRESS<br>Reisterstown, Md.                                                                                                                                |                                                                                            |                                                                   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 06 1987                 |                                                                                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                          |                                                                                                                                           |                                                                      |                                                                         | 25b. REGISTRAR'S SIGNATURE<br><i>Alia Davidson-Randall</i>                                                                                                  |                                                                                            |                                                                   |                                                              |                                                                                                                                                                 |  |

MEDICAL CERTIFICATION



9025 OCT-8 61





070414 NOV-287

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                          |                                                                                                                                            |                                              |                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dora Lee Wiley                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 29, 1987                   |                                                                                                                                                             |                                                          | 2b. HOUR<br>4:30 AM                                                                                                                        |                                              |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>White                                                                                                                      |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 1, 1905                                                                                                          |                                                          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82<br>YRS.                                                                                              |                                              | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                               |                                              |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Old Court Nursing Center |                                                                        |                                                                                                                                                             |                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housework                                                              |                                              | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home Keeping                                                                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                          |                                                                                                                                            |                                              |                                                                                                                            |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>Balto.                                                                                                                 |                                                                        | 13c. CITY OR TOWN<br>Pikesville                                                                                                                             |                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |                                              | 13e. STREET ADDRESS / ZIP CODE<br>101 Mt. Wilson Lane 21208                                                                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Wiley                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Cora Smith                                                                                                 |                                                          |                                                                                                                                            |                                              |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-30-5336                                                                |                                                                        | 17. INFORMANT<br>ADDRESS<br>Lena H. Kranz 101 Mt. Wilson Lane<br>Pikesville, Md. 21208                                                                      |                                                          |                                                                                                                                            |                                              |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                          |                                                                                                                                            |                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>death</u><br><u>year</u>                                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Pituitary tumor</u>                                                                                                                                                                                                                             |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                          |                                                                                                                                            |                                              |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                       |                                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                  |  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                             |                                              |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                              |  |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             |                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                              |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                               |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                          |                                                                                                                                            |                                              |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>Dora Lee Wiley</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       | DEGREE<br><u>M.D.</u>                                                  |                                                                                                                                                             |                                                          | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                              | 22c. DATE SIGNED<br>10/30/87                                                                                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dora Lee Wiley                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                       | 22e. ADDRESS<br>10219 S. Delaplace Rd Owings Mills, Md.                |                                                                                                                                                             |                                                          |                                                                                                                                            |                                              |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                       | 23b. DATE<br>Oct. 30, 1987                                             |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park |                                                                                                                                            | 23d. LOCATION<br>Baltimore, Md. COUNTY STATE |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>H. G. Schuchardt                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                          | 25a. DATE RECEIVED BY REGISTRAR<br>OCT 30 1987                                                                                             |                                              | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                           |  |
| ADDRESS<br>Owings Mills, Md.                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                          |                                                                                                                                            |                                              |                                                                                                                            |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

070414 NOV-50

| Date         | Age | Sex  | Place of Birth | Place of Birth | Place of Birth |
|--------------|-----|------|----------------|----------------|----------------|
| Nov. 1, 1902 | 48  | Male | U.S.A.         | U.S.A.         | U.S.A.         |
| Nov. 1, 1902 | 48  | Male | U.S.A.         | U.S.A.         | U.S.A.         |
| Nov. 1, 1902 | 48  | Male | U.S.A.         | U.S.A.         | U.S.A.         |
| Nov. 1, 1902 | 48  | Male | U.S.A.         | U.S.A.         | U.S.A.         |
| Nov. 1, 1902 | 48  | Male | U.S.A.         | U.S.A.         | U.S.A.         |
| Nov. 1, 1902 | 48  | Male | U.S.A.         | U.S.A.         | U.S.A.         |
| Nov. 1, 1902 | 48  | Male | U.S.A.         | U.S.A.         | U.S.A.         |
| Nov. 1, 1902 | 48  | Male | U.S.A.         | U.S.A.         | U.S.A.         |
| Nov. 1, 1902 | 48  | Male | U.S.A.         | U.S.A.         | U.S.A.         |
| Nov. 1, 1902 | 48  | Male | U.S.A.         | U.S.A.         | U.S.A.         |

COPIED

OCT 30 1950

069186 OCT 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                     |                                                                                                                          |                                                                                                                                                             |                                                                                 |                                                                                                                                               |                                                         |                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA                                                                                                                                                                                                                                                                         |                                                                                                                          | FIRST<br>ANNA                                                                                                                                               | MIDDLE<br>V.                                                                    | LAST<br>WILHELM                                                                                                                               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-13-87         | 2b. HOUR<br>12 PM                                                                                                                     |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                    | 4. RACE<br>CAUC                                                                                                          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-10-1894                                                                                                            |                                                                                 | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>92                                                                                                       | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.            |                                                                                                                                       |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT. COUNTY MD.                                                                                      |                                                         |                                                                                                                                       |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                 | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PICKERSGILL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OFFICE WORK |                                                                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY                       |                                                                                                                                       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>1a. STATE<br>MD                                                                                                                                                                                                     |                                                                                                                          | 13b. COUNTY<br>BALT                                                                                                                                         | 13c. CITY OR TOWN<br>BALT                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                               | 13e. STREET ADDRESS / ZIP CODE<br>1925 C. 31st ST 21218 |                                                                                                                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MITCHELL WILHELM SUSIE                                                                                                                                                                                                                                                    |                                                                                                                          | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HENDERSON                                                                                                  |                                                                                 | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                         |                                                         |                                                                                                                                       |
| 17. SOCIAL SECURITY NO.<br>215-22-2908                                                                                                                                                                                                                                                                              |                                                                                                                          | 17. INFORMANT<br>Pickersgill Home                                                                                                                           |                                                                                 | 17. INFORMANT<br>Valeria Latach                                                                                                               |                                                         |                                                                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                                          | Pneumonia, Hepatoma<br>Sementine<br>Cerebrovascular Disease                                                                                                 |                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days<br>Many years                                                                          |                                                         |                                                                                                                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                  |                                                                                                                          |                                                                                                                                                             |                                                                                 |                                                                                                                                               |                                                         |                                                                                                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                              |                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                          |                                                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                            |                                                                                                                          | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                |                                                         |                                                                                                                                       |
| 21d. INJURY OCCURRED<br>WHILE WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                              |                                                                                                                          | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                 | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE                                                                                                    |                                                         |                                                                                                                                       |
| 22a. I certify that (I) (the hospital) attended the deceased from June 1987 to Oct 13 1987, that (I) (we) last saw the deceased alive on 10-12-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.             |                                                                                                                          |                                                                                                                                                             |                                                                                 |                                                                                                                                               |                                                         |                                                                                                                                       |
| 22b. SIGNATURE<br>K. A. MANLEY                                                                                                                                                                                                                                                                                      |                                                                                                                          | DEGREE<br>MD                                                                                                                                                |                                                                                 | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                                         | 22c. DATE SIGNED<br>10-14-87                                                                                                          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K.A. MANLEY                                                                                                                                                                                                                                                                |                                                                                                                          | 22e. ADDRESS<br>Pot Spring Rd., Timonium, Md. 21093                                                                                                         |                                                                                 |                                                                                                                                               |                                                         |                                                                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                              |                                                                                                                          | 23b. DATE<br>10-16-87                                                                                                                                       |                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery                                                                                    |                                                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, Balto., Md.                                                                 |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.,                                                                                                                                                                                                                                                     |                                                                                                                          | ADDRESS<br>1050 York Rd.<br>Towson, Md. 21204                                                                                                               |                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>OCT 16 1987                                                                                                  |                                                         | 25b. REGISTRAR'S SIGNATURE<br>Julia Dandridge-Rudolph                                                                                 |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove entire papers, Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28357

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Austin</b> <b>WILKENS</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                       | 2a. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>21</b> YEAR <b>87</b>       |                                                                                                                                                             |                                                                                                                                                      | 2b. HOUR<br><b>12:15</b> <b>AM</b>                               |                                                                                                 |                                                                                      |                                                                                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>Black</b>                                                                                                               |                                                                        | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>01</b> YEAR <b>28</b>                                                                                             |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> <b>59</b> YRS.      |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS <b>59</b> DAYS <b>59</b> HOURS <b>59</b> MIN.              |                                                                                                                            |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                         |                                                                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.     |                                                                                                 |                                                                                      |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa St. Michael</b> |                                                                        |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |                                                                                                                            |  |
| 13a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       | 13b. COUNTY                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                |                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      | 13e. STREET ADDRESS<br><b>523 N. Washington</b>                                                                            |  |
| 14. FATHER'S NAME<br>FIRST <b>Austin</b> MIDDLE <b>Wilkens</b> LAST <b>Wilkens</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rose</b> MIDDLE <b>Wilkens</b> LAST <b>Wilkens</b>                                                              |                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES <input checked="" type="checkbox"/> OR UNKNOWN)                                                                                                                                                                                                                                                                  |  |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br><b>219-189890</b>                          |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br><b>Chart 4800 Seton Drive</b>                                                                                            |                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bladder Cancer with liver metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                  |                                                                                                 |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                    |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                      |                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                               |  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                        |  |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/4/87</b> , 19____, to <b>9/21/87</b> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |                                                                                                                                       |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |  |
| 22b. SIGNATURE<br><b>Tasneem Lakhani</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                  |                                                                                                 | 22c. DATE SIGNED<br><b>9/21/87</b>                                                   |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TASNEEM LAKHANI</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><b>7220 Park Heights Ave, Balto MD 21208</b>                                                                                         |                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                       | 23b. DATE<br><b>9-25-87</b>                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet</b>                                                                                     |                                                                  |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN <b>OWINGS Mills</b> COUNTY <b>Md.</b> STATE <b>MD.</b> |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. Brown</b> ADDRESS <b>1206 W. North Ave</b>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                       |                                                                        |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR <b>OCT 19 1987</b> 25b. REGISTRAR'S SIGNATURE <b>L. E. Swindon-Randall</b>                                             |                                                                  |                                                                                                 |                                                                                      |                                                                                                                            |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed from the carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                          |                              |                                                                                                           |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                               |                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| DECEASED NAME<br>(PRINT)                                                                                                                                                                                                                                                                                                                                                 |                              | FIRST                                                                                                     | MIDDLE                                                                                                                                                      | LAST                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR                                                  |                                                                                                 | 2b. HOUR<br>M                                                                                                                 |                                                                      |
| DOROTHY                                                                                                                                                                                                                                                                                                                                                                  |                              | ROSEBERRY                                                                                                 | WILLARD                                                                                                                                                     | OCTOBER 18, 1987                                                               |                                                                                      |                                                                                                 |                                                                                                                               |                                                                      |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE                      |                                                                                                           | 5. DATE OF BIRTH<br>MONTH DAY YEAR                                                                                                                          |                                                                                | 6. AGE (IN YEARS LAST BIRTHDAY)                                                      |                                                                                                 | 7. UNDER 1 YEAR<br>MONTHS DAYS                                                                                                |                                                                      |
| Female                                                                                                                                                                                                                                                                                                                                                                   | White                        |                                                                                                           | Sept. 29, 1913                                                                                                                                              |                                                                                | 74                                                                                   |                                                                                                 | YRS. MONTHS DAYS HOURS MIN.                                                                                                   |                                                                      |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY? |                                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                | 9. BALTIMORE CITY OR COUNTY OF DEATH                                                 |                                                                                                 |                                                                                                                               |                                                                      |
| Maryland                                                                                                                                                                                                                                                                                                                                                                 | USA                          |                                                                                                           |                                                                                                                                                             |                                                                                | Baltimore County MD.                                                                 |                                                                                                 |                                                                                                                               |                                                                      |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |                                                                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                             |                                                                      |
| Towson                                                                                                                                                                                                                                                                                                                                                                   |                              | St. Joseph Hospital                                                                                       |                                                                                                                                                             |                                                                                | Teacher                                                                              |                                                                                                 | Education                                                                                                                     |                                                                      |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                                               |                              |                                                                                                           |                                                                                                                                                             | 13b. COUNTY                                                                    | 13c. CITY OR TOWN                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                               |                                                                      |
| Maryland                                                                                                                                                                                                                                                                                                                                                                 |                              |                                                                                                           |                                                                                                                                                             | Baltimore                                                                      | Owings Mills                                                                         | 13e. STREET ADDRESS / ZIP CODE                                                                  |                                                                                                                               |                                                                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                   |                              |                                                                                                           |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                  |                                                                                      |                                                                                                 |                                                                                                                               |                                                                      |
| Richard Walter Gray                                                                                                                                                                                                                                                                                                                                                      |                              |                                                                                                           |                                                                                                                                                             | Jessie Roseberry                                                               |                                                                                      |                                                                                                 |                                                                                                                               |                                                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)                                                                                                                                                                                                                                                                         |                              | 16b. SOCIAL SECURITY NO.                                                                                  |                                                                                                                                                             | 17. INFORMANT                                                                  |                                                                                      | ADDRESS                                                                                         |                                                                                                                               |                                                                      |
| No                                                                                                                                                                                                                                                                                                                                                                       |                              | 212-32-0441                                                                                               |                                                                                                                                                             | Robert W. Willard                                                              |                                                                                      | 420 E. 72nd St.<br>New York, N.Y. 10021                                                         |                                                                                                                               |                                                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>                                                                                                                                                                                                                    |                              |                                                                                                           |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>10 minutes</u> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEVERE COPD &amp; asthma</u>                                                                                                                                                                                                                                                                                                    |                              |                                                                                                           |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                               | <u>&gt;10 yrs</u>                                                    |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CHF</u>                                                                                                                                                                                                                                                                                                                         |                              |                                                                                                           |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                               | <u>5 yrs</u>                                                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                                     |                              |                                                                                                           |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                               |                                                                      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                                                                                                                                                             |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                                                           |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                                                                      |                                                                                                 |                                                                                                                               |                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                          |                              | P.M. 19                                                                                                   |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                               |                                                                      |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                       |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                      |                                                                                                 |                                                                                                                               |                                                                      |
|                                                                                                                                                                                                                                                                                                                                                                          |                              |                                                                                                           |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                               |                                                                      |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>8-4</u> , 19 <u>87</u> , to <u>10-18</u> , 19 <u>87</u> , that (1) (we) lost<br>saw the deceased alive on <u>9-25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |                              |                                                                                                           |                                                                                                                                                             |                                                                                |                                                                                      |                                                                                                 |                                                                                                                               |                                                                      |
| 22b. SIGNATURE<br><u>William E. Randall, Jr.</u>                                                                                                                                                                                                                                                                                                                         |                              |                                                                                                           |                                                                                                                                                             |                                                                                | DEGREE<br><u>MD</u>                                                                  |                                                                                                 | 22c. DATE SIGNED<br><u>10/20/87</u>                                                                                           |                                                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William E. Randall, Jr., M.D.                                                                                                                                                                                                                                                                                                   |                              |                                                                                                           |                                                                                                                                                             |                                                                                | 22e. ADDRESS<br>1205 York Rd. Lutherville, Md. 21093                                 |                                                                                                 |                                                                                                                               |                                                                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                             |                              | 23b. DATE                                                                                                 |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                                      |                                                                                                                               |                                                                      |
| Cremation                                                                                                                                                                                                                                                                                                                                                                |                              | Oct. 20, 1987                                                                                             |                                                                                                                                                             | Greenmount                                                                     |                                                                                      | Baltimore City, Maryland                                                                        |                                                                                                                               |                                                                      |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS                                                                                                                                                                                                                                                                                                                                     |                              |                                                                                                           |                                                                                                                                                             | 25a. DATE REC'D. BY REGISTRAR                                                  |                                                                                      | 25b. REGISTRAR'S SIGNATURE                                                                      |                                                                                                                               |                                                                      |
| Mitchell-Wiedefeld & Home, Inc. Baltimore, Md.                                                                                                                                                                                                                                                                                                                           |                              |                                                                                                           |                                                                                                                                                             | 6500 York Rd.<br>201 23 1987                                                   |                                                                                      | <u>John Davidson</u>                                                                            |                                                                                                                               |                                                                      |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                    |                                                                                                                                           |                                                                                                 |                                                                                                                            |                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Gerard F. Wille SR.                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-5-87                         |                                                                                                                                                             |                                                                    | 2b. HOUR<br>3:05 PM                                                                                                                       |                                                                                                 |                                                                                                                            |                                                        |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>Caucasian                                                                                                        |                                                                        | 5. DATE OF BIRTH<br>(MONTH DAY YEAR)<br>5-15-1902                                                                                                           |                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 yrs.                                                                                                |                                                                                                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                               |                                                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                         |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                                                              |                                                                                                 |                                                                                                                            |                                                        |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3606 Bay Drive |                                                                        |                                                                                                                                                             |                                                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman                                                               |                                                                                                 | 12b. KIND OF BUSINESS, OR INDUSTRY<br>Electric Co.                                                                         |                                                        |  |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             | 13b. CITY OR TOWN<br>Balto.                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>Balto.                                        |                                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br>3606 Bay Drive 21220 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick Wille                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                             |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Caroline Heim                                                                                              |                                                                    |                                                                                                                                           |                                                                                                 |                                                                                                                            |                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                             | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-05-5144 |                                                                                                                                                             | 17. INFORMANT<br>ADDRESS<br>Dolores Zorn 1227 Sellier Avenue 21237 |                                                                                                                                           |                                                                                                 |                                                                                                                            |                                                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Infected Right Above Knee Amputation Stump</u> |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                    |                                                                                                                                           |                                                                                                 |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>                                                                                                                                                                                                                                                                           |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                    |                                                                                                                                           |                                                                                                 |                                                                                                                            |                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                 |                                                                                                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                             |  |                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             |                                                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                                             |                                                                                                 |                                                                                                                            |                                                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                         |  |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |                                                                                                                                                             |                                                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                         |                                                                                                 |                                                                                                                            |                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                                       |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                    |                                                                                                                                           |                                                                                                 |                                                                                                                            |                                                        |  |
| 22b. SIGNATURE<br><u>D Fakhouri</u> MD                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                    | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                 |                                                                                                                            | 22c. DATE SIGNED<br>10/6/87                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Fakhouri                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                    | 22e. ADDRESS<br>901 Eastern Avenue 2nd floor                                                                                              |                                                                                                 |                                                                                                                            |                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                             | 23b. DATE<br>10-8-87                                                   |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.           |                                                                                                                                           |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                                                                  |                                                        |  |
| 24. FUNERAL DIRECTOR<br>Schlunke Funeral Home, Inc.<br>9705 Belair Road, Balto., MD. 21236                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                    | 25a. DATE REC'D. BY REGISTRAR<br>OCT 09 1987                                                                                              |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>John Swindon Rodell</u>                                                                   |                                                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return original papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                     |                                                                                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                            | REG. NO.                                                                                        |                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Beulah H. Williams                                                                                                                                                                                                                                                                                           |                                                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-4-87                   |                                                                                                                                            | 2b. HOUR<br>7:15 PM                                                                             |                                                                                                                               |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br>Black                                                                                                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9-17-1916                                                                                                             |                                                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS                                                                                                  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |                                                                                                                               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                                                               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                                                               |                                                                                                 |                                                                                                                               |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. CO., GENERAL HOSP. |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                                                                                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE MARYLAND                                                                                                                                                                                                                                                       |                                                                                                                                        |                                                                                                                                                             | 13b. COUNTY                                                      | 13c. CITY OR TOWN<br>BALTIMORE                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALFRED HARRIS                                                                                                                                                                                                                                                                                                                  |                                                                                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ROSELLA         |                                                                                                                                            |                                                                                                 |                                                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO.                                                                                                                                                                                                                                                                                              |                                                                                                                                        | 16b. SOCIAL SECURITY NO.<br>212-28-6317                                                                                                                     |                                                                  | 17. INFORMANT<br>3104 ELBA DR. 21207<br>JUANITA + VERNON WILLIAMS, BALTO. MD.                                                              |                                                                                                 |                                                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Overwhelming sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Renal Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Respiratory Failure</u>                                                                             |                                                                                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>C.O.P.D.; C.A.D.</u>                                                                                                                                                                                                                 |                                                                                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                  |                                                                                                 | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                 |                                                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                             |                                                                                                 |                                                                                                                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                             |                                                                                                                                        | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                          |                                                                                                 |                                                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-12</u> , 19 <u>87</u> , to <u>10-4</u> , 19 <u>87</u> , that (I) (we) lost<br>saw the deceased alive on <u>10-4</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                        |                                                                                                                                                             |                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                               |
| 22b. SIGNATURE<br><u>Allan J. Chircus M.D.</u>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                        | DEGREE                                                                                                                                                      |                                                                  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><u>10-4-87</u>                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Allan J. Chircus M.D.                                                                                                                                                                                                                                                                                                           |                                                                                                                                        | 22e. ADDRESS<br>Baltimore County General Hosp.                                                                                                              |                                                                  |                                                                                                                                            |                                                                                                 |                                                                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                   |                                                                                                                                        | 23b. DATE<br>10/9/1987                                                                                                                                      |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEM. PARK                                                                                    |                                                                                                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, MD.                                                                  |
| 24. FUNERAL DIRECTOR<br>(NAME) ADDRESS<br>NUTTER FUNERAL HOMES, INC.<br>2501 GWYNNS FAUS PKWY, BALTO. MD. 21216                                                                                                                                                                                                                                                          |                                                                                                                                        |                                                                                                                                                             |                                                                  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 07 1987                                                                                               |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>John A. ...</u>                                                                              |



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                                                              |                                                   |                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Bobbie Jean Williams</b>                                                                                                                                                                                                                                                                                                                                                                                  |                         | 2a. DATE KNOWN OF DEATH ESTIMATED<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br><b>10 25 87</b> |                                                   | 2b. HOUR<br><b>5A</b>                                                                                                                                       |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 3, 1970</b>                                                                                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>17 YRS.</b> | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN<br><b>0 0 0 0</b>                                                                                              |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                     |                         | 7c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                |                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br><b>21234</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Cromwell Bridge Road 21234</b>                 |                                                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>                                                                             |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                              |                                                   | 13c. CITY OR TOWN<br><b>21234</b>                                                                                                                           |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Dale A. Williams</b>                                                                                                                                                                                                                                                                                                                                                                                |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jeanne M. Deal</b>                                                                                       |                                                   |                                                                                                                                                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                  |                         | 16b. SOCIAL SECURITY NO.<br><b>217-11-1374</b>                                                                                                               |                                                   | 17. INFORMANT<br>ADDRESS<br><b>Dale A. &amp; Jeanne Williams Balto., MD. 21234</b>                                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cranio cerebral trauma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                                                                     |                         |                                                                                                                                                              |                                                   |                                                                                                                                                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                                                                                                                                                                                                                                                                                                              |                         |                                                                                                                                                              |                                                   |                                                                                                                                                             |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                           |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                            |                                                   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>4 <del>xxx</del> 10 25 87</b>                                                                                                                                                                                                                                                                               |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4 10 25 87</b>                                                                                         |                                                   |                                                                                                                                                             |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Passenger in auto/auto impact</b>                                        |                                                   |                                                                                                                                                             |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>                                                                                                                                                                                                                                                                                                                                                                       |                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Cromwell Bridge Rd, Balto.Co, MD.</b>                                                                |                                                   |                                                                                                                                                             |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                         |                                                                                                                                                              |                                                   |                                                                                                                                                             |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>                                                                                                                                                                                                                                                                                                                                                                                                       |                         | TITLE (SPECIFY)<br><b>Assistant</b>                                                                                                                          |                                                   | MEDICAL EXAMINER<br>DATE SIGNED <b>10/25/87</b>                                                                                                             |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                  |                         | ADDRESS<br><b>111 Penn St. Balto.MD.</b>                                                                                                                     |                                                   |                                                                                                                                                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                       |                         | 23b. DATE<br><b>OCT. 28, '87</b>                                                                                                                             |                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEMETERY</b>                                                                                              |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>                                                                                                                                                                                                                                                                                                                                                                                        |                         | ADDRESS<br><b>8521 LOCH RAVEN BLVD.</b>                                                                                                                      |                                                   |                                                                                                                                                             |
| 25a. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |                         | 25b. REGISTRAR'S SIGNATURE                                                                                                                                   |                                                   |                                                                                                                                                             |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3, (RETAIN PAGE 4 FOR YOUR FILES). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSITMENT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 28342

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                       |                                                                                                                                                              |                                                                                                 |                                                                           |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hilda Katherine Williams                                                                                                                                                                                                                                                                                                               |                                                                                                                                       |                                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 4, 1987                                          |                                                                           | 2b. HOUR<br>11:20 PM                                                                                                       |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                              | 4. RACE<br>White                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 19, 1924                                                                                                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63<br>YRS                                                    | 7. UNDER 1 YEAR<br>MONTHS DAYS                                            | 8. UNDER 24 HRS.<br>HOURS MIN.                                                                                             |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                         | 9b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |                                                                           |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Rossville                                                                                                                                                                                                                                                                                                                                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |                                                                                                                                                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired-waitress            | 12b. KIND OF BUSINESS OR INDUSTRY<br>Cook                                 |                                                                                                                            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                       |                                                                                                                                       |                                                                                                                                                              |                                                                                                 |                                                                           |                                                                                                                            |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                             | 13b. COUNTY<br>Balto.                                                                                                                 | 13c. CITY OR TOWN<br>Middle River                                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>15 W. Hickam Road 21220                 |                                                                                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Cornelius Berger                                                                                                                                                                                                                                                                                                                    |                                                                                                                                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lydia Leach                                                                                                 |                                                                                                 |                                                                           |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no                                                                                                                                                                                                                                                                        |                                                                                                                                       | 16b. SOCIAL SECURITY NO.<br>216-14-8494                                                                                                                      |                                                                                                 | 17. INFORMANT ADDRESS<br>Colon Patton Williams 15 Hickam Road 21220       |                                                                                                                            |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____ |                                                                                                                                       |                                                                                                                                                              |                                                                                                 |                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                        |                                                                                                                                       |                                                                                                                                                              |                                                                                                 |                                                                           |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                         |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                           |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                           |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                   |                                                                                                                                       |                                                                                                                                                              |                                                                                                 |                                                                           |                                                                                                                            |
| 22b. SIGNATURE<br><u>Joseph Connelly</u>                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                       | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                    |                                                                                                 | 22c. DATE SIGNED<br>10/5/87                                               |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Joseph Connelly                                                                                                                                                                                                                                                                                                                  |                                                                                                                                       | 22e. ADDRESS<br>805 Fuselage Ave. 21220                                                                                                                      |                                                                                                 |                                                                           |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                           | 23b. DATE<br>10/8/87                                                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Cemetery                                                                                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Middle River Balto. Maryland                      |                                                                           |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>Connelly funeral Home 300 Mace Ave. 21221                                                                                                                                                                                                                                                                                                             |                                                                                                                                       |                                                                                                                                                              | 25a. DATE REC'D. BY REGISTRAR<br>OCT 6 1987                                                     | 25b. REGISTRAR'S SIGNATURE<br><u>Lelia Davidson-Randall</u>               |                                                                                                                            |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert certificate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten notes on lined paper, including the word "SCHOOL" and other illegible text.

Vertical text on the right margin, possibly a date or page number.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>REGISTRAR                                                                                                                                                                                                                                                                              |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                      |  | REG. NO.                                                                       |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                    |  | FIRST MIDDLE LAST                                                                                         |  | 2a. DATE OF DEATH MONTH DAY YEAR                                               |                                              |
| Frank                                                                                                                                                                                                                                                                                                                                                  |  | Wilson                                                                                                    |  | 10 13 87                                                                       |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                                                   |  | 5. DATE OF BIRTH MONTH DAY YEAR                                                |                                              |
| Male                                                                                                                                                                                                                                                                                                                                                   |  | Caucasian                                                                                                 |  | 03 16 1903                                                                     |                                              |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                                |                                              |
| MD                                                                                                                                                                                                                                                                                                                                                     |  | USA                                                                                                       |  | 84 YRS.                                                                        |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                              |
| Catonsville                                                                                                                                                                                                                                                                                                                                            |  | Summit Nursing Home 21228                                                                                 |  | Baltimore County MD.                                                           |                                              |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                         |  | 12c. KIND OF BUSINESS OR INDUSTRY                                              |                                              |
| 13a. STATE                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                                               |  | 13c. STREET ADDRESS                                                            |                                              |
| MD                                                                                                                                                                                                                                                                                                                                                     |  | Baltimore                                                                                                 |  | 5 Park Drive 21228                                                             |                                              |
| 14. FATHER'S NAME FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                                                |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)            |                                              |
| Frank Wilson                                                                                                                                                                                                                                                                                                                                           |  | Katherine Anne Heinmuller                                                                                 |  | NO                                                                             |                                              |
| 17a. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                               |  | 17b. INFORMANT                                                                                            |  | 17c. ADDRESS                                                                   |                                              |
| 212-09-2206                                                                                                                                                                                                                                                                                                                                            |  | Margaret L. Wilson                                                                                        |  | Same as #13                                                                    |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Severe Cerebral Vascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arrhythmia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____                                                                           |  |                                                                                                           |  |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                                |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a. AUTOPSY?                                                                  |                                              |
|                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                           |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 31, 1987</u> to <u>October 13, 1987</u> , that (I) (we) last saw the deceased alive on <u>October 12, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>James E. Rowe MD</u>                                                                 |  | 22c. DATE SIGNED<br><u>10-13-87</u>                                            |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                  |  | 22e. ADDRESS                                                                                              |  | 22f. DATE SIGNED                                                               |                                              |
| James Rowe, MD                                                                                                                                                                                                                                                                                                                                         |  | 413 Commonwealth Ave. 21228                                                                               |  |                                                                                |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                           |  | 23b. DATE                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                 |  | 10-15-87                                                                                                  |  | Loudon Park Cem. Baltimore, MD                                                 |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                   |  | 24b. DATE REC'D. BY REGISTRAR                                                                             |  | 24c. REGISTRAR'S SIGNATURE                                                     |                                              |
| MacNabb Funeral Home, Catonsville, MD                                                                                                                                                                                                                                                                                                                  |  | OCT 13 1987                                                                                               |  | <u>John Davidson</u>                                                           |                                              |

080207 OCT 14 03

FROM: [illegible]

TO: [illegible]

RE: [illegible]

DATE: [illegible]

OCT 13 1963

070884 NOV-587

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 28344

|                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                   |                                              |                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Myrtle P. Winsree                                                                                                                                                                                                                               |  |                                                                                                                                   | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 31 82 |                                                                                                                                                                                                                                                                                                                                                                                       |  | 2b. HOUR<br>6 30 A.M.                                                                                                      |  |
| 3. SEX<br>FEMALE                                                                                                                                                                                                                                                                                         |  | 4. RACE<br>WHITE                                                                                                                  |                                              | 5. DATE OF BIRTH MONTH DAY YEAR<br>MAR 4, 1891                                                                                                                                                                                                                                                                                                                                        |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.                                                                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                            |                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                           |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE MD.                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8527 Stevenswood Rd. |                                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                                                                                                                                                                                                                                                                                                         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME                                                                              |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.                                                                                                                                                                                        |  | 13b. CITY OR TOWN<br>BALTIMORE                                                                                                    |                                              | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                       |  | 13d. STREET ADDRESS<br>8527 Stevenswood Rd.                                                                                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ROBERT F. PERINE                                                                                                                                                                                                                                                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>IDA WRIGHT                                                                          |                                              | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>220-52-8023                                                                                    |  |
| 17. INFORMANT<br>George W. Winfree                                                                                                                                                                                                                                                                       |  | ADDRESS<br>HOBOKEN NJ                                                                                                             |                                              | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) acute congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) 5 years<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hrs.                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                      |  |                                                                                                                                   |                                              |                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                  |                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                        |                                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)                                                                                                                                                                                                                                                                                                        |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                            |                                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 75 to 10/31 1982, that (I) (we) last saw the deceased alive on 10/1 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                   |                                              |                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>M. J. Ellen                                                                                                                                                                                                                                                                            |  | DEGREE                                                                                                                            |                                              | 22c. DATE SIGNED<br>10/31/82                                                                                                                                                                                                                                                                                                                                                          |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. J. Ellen                                                                       |  |
| 22e. ADDRESS<br>5310 Old Cant Rd                                                                                                                                                                                                                                                                         |  | 22f. ADDRESS<br>Randy's Room, Md.                                                                                                 |                                              | 22g. ADDRESS<br>21183                                                                                                                                                                                                                                                                                                                                                                 |  | 22h. ADDRESS                                                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                   |  | 23b. DATE<br>11/3/1987                                                                                                            |                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>St Paul's Churchyard                                                                                                                                                                                                                                                                                                                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>HOBOKEN NJ                                                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Baker & Bouchs, Salisbury Md.                                                                                                                                                                                                                                            |  | ADDRESS                                                                                                                           |                                              | 25a. DATE REC'D. BY REGISTRAR<br>NOV 4 1987                                                                                                                                                                                                                                                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br>John E. ...                                                                                  |  |

BP  
DHMH - 16 50M 1/81  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                 |  |                                                                                                                                          |  | REG. NO.                                                                                                                                          |  |                                                                                                                            |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Gloria M. Wisniewski</b>                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                          |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 14 87</b>                                                                                            |  | 2b. HOUR<br><b>12 AM</b>                                                                                                   |                                              |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>Caucasian</b>                                                                                                              |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 19 47</b>                                                                                             |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>39</b> YRS.                                                                          |                                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.                                                                                  |  |                                                                                                                            |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Towson Md</b>                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sec.</b>                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO. Co.</b>                                                                     |                                              |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                                          |  | 13c. CITY OR TOWN<br><b>PERRY HALL</b>                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |                                              |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CARROLL P. MILLER</b>                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA L. TOMPSON</b>                                                                  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                     |  |                                                                                                                            |                                              |
| 16b. SOCIAL SECURITY NO.<br><b>215-505801</b>                                                                                                                                                                                                                                                                                                                        |  | 17. INFORMANT<br><b>FAMILY RECORDS</b>                                                                                                   |  | ADDRESS                                                                                                                                           |  |                                                                                                                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Glioblastoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                   |  |                                                                                                                                          |  |                                                                                                                                                   |  |                                                                                                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                               |  |                                                                                                                                          |  |                                                                                                                                                   |  |                                                                                                                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                                                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                                                    |  |                                                                                                                            |                                              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                 |  |                                                                                                                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-16</b> , 19 <b>87</b> , to <b>10-14</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10/14</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                                                          |  |                                                                                                                                                   |  |                                                                                                                            |                                              |
| 22b. SIGNATURE<br><b>Carla S. Alexander</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                          |  | DEGREE<br><b>PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/14/87</b>                                                                                        |                                              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carla S. Alexander, M.D.</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                          |  | 22e. ADDRESS<br><b>Stella Maris Hospice<br/>Dulaney Valley Rd. - Towson, MD 21204</b>                                                             |  |                                                                                                                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>10-14-1987</b>                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>                                                                                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                                                    |                                              |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPEL OF MEMORIES ROAD 8800 HARFORD</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                                          |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1987</b>                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                                                |                                              |

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10 55 120 5 16 2 80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 7/84  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                       |                                                                                                                                                      |                                                                                                                                                             |                                                             |                                                                                                 |                                                                                      |                                                                      |                                                                                                                                       |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SIMON C. WOLMAN                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |                                                                                                                                                      |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCT. 3, 1987         |                                                                                                 |                                                                                      |                                                                      |                                                                                                                                       | 2b. HOUR<br>9:25 A.M.                        |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>WHITE                                                                                                                      |                                                                                                                                                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>November 6, 1902                                                                                                      |                                                             |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS                                            |                                                                      | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                                                      |                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>U.S.A. Maryland                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                |                                                                                                                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                             | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |                                                                                      |                                                                      |                                                                                                                                       |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>PIKESVILLE                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JEWISH CONVALESCENT HOME |                                                                                                                                                      |                                                                                                                                                             |                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>Executive                    |                                                                                      |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Cleaning Empire Bldg and                                                                         |                                              |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br>Baltimore                                                                                                              |                                                                                                                                                      | 13c. CITY OR TOWN<br>Pikesville                                                                                                                             |                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                      | 13e. STREET ADDRESS / ZIP CODE<br>11 Slade Avenue Apt. 706 (21208)   |                                                                                                                                       |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Hyman Wolman                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       |                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Unknown                                                                                               |                                                             |                                                                                                 |                                                                                      |                                                                      |                                                                                                                                       |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br>215-05-1043                                                                                               |                                                                                                                                                      | 17. INFORMANT<br>Mrs. Sarah Wolman                                                                                                                          |                                                             |                                                                                                 |                                                                                      | ADDRESS<br>11 Slade Avenue Apt. 706                                  |                                                                                                                                       |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                                                       |                                                                                                                                                      |                                                                                                                                                             |                                                             |                                                                                                 |                                                                                      |                                                                      |                                                                                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u>                                                                                                                                                                                               |  |                                                                                                                                       |                                                                                                                                                      |                                                                                                                                                             |                                                             |                                                                                                 |                                                                                      |                                                                      |                                                                                                                                       |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                     |                                                                                                                                                             |                                                             |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                               |  |                                                                                                                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. _____ 19 _____                                                                               |                                                                                                                                                             |                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                      |                                                                      |                                                                                                                                       |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                        |  |                                                                                                                                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                               |                                                                                                                                                             |                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                      |                                                                      |                                                                                                                                       |                                              |  |
| 22a. I certify that I (with _____) attended the deceased from _____, 19 _____, to _____, 19 _____, that (1) _____ saw the deceased alive on _____, 19 _____, and that in (my) _____ opinion, death occurred on the date and hour and from the causes stated above (1) _____ and did not view the body after death.                                                                    |  |                                                                                                                                       |                                                                                                                                                      |                                                                                                                                                             |                                                             |                                                                                                 |                                                                                      |                                                                      |                                                                                                                                       |                                              |  |
| 22b. SIGNATURE<br><u>Howard B. Cohen, M.D.</u>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                                                                                             |                                                             | 22c. DATE SIGNED<br>10/3/87                                                                     |                                                                                      |                                                                      |                                                                                                                                       |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Howard B. Cohen, M.D.                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                       | 22e. ADDRESS<br>6610 CROSS COUNTRY BLVD                                                                                                              |                                                                                                                                                             |                                                             |                                                                                                 |                                                                                      |                                                                      |                                                                                                                                       |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                       | 23b. DATE<br>October 4/87                                                                                                                            |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH EL MEMORIAL PARK |                                                                                                 |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>RANDALLSTOWN BALTO. MD |                                                                                                                                       |                                              |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD., BALTO., MD 21215                                                                                                                                                                                                                                                                            |  |                                                                                                                                       |                                                                                                                                                      |                                                                                                                                                             |                                                             | 25a. DATE REC'D. BY REGISTRAR<br>OCT 08 1987                                                    |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                 |                                                                                                                                       |                                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                      |                                                                                                                                    |                                                                                                                                                             |                                                                                                 | REG. NO. 28347                                                                       |                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE E. LAST WOMACK                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 25, 1987                                         |                                                                                      | 2b. HOUR<br>2:00A <sub>M</sub>                                   |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br>White                                                                                                                   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 1, 1902                                                                                                           |                                                                                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.                                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                        |                                                                  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Edenwald Nursing Home |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker                  |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                    |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                      |                                                                  |
| 14. FATHER'S NAME<br>FIRST Ephraim MIDDLE A. LAST Boring                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                    |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST Harriett MIDDLE M. LAST Boring                                |                                                                                      |                                                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No                                                                                                                                                                                                                                                                                                                   |                                                                                                                                    | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-05-8069                                                                                      |                                                                                                 | 17. INFORMANT<br>Charles E. Boring                                                   |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    |                                                                                                                                                             |                                                                                                 | ADDRESS<br>800 Southerly Rd. Apt. 606 21204 1608                                     |                                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE<br>Advanced end stage Alzheimer's disease<br>Chronic bronchitis<br>DUE TO (a) A CONSEQUENCE OF<br>DUE TO (b) A CONSEQUENCE OF<br>DUE TO (c) A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |                                                                                                                                    |                                                                                                                                                             |                                                                                                 |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:                                                                                                                                                                                                                                                          |                                                                                                                                    |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                |                                                                                                                                    |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)       |                                                                  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                            |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                                 | 21f. LOCATION<br>CITY OR TOWN STREET COUNTY STATE                                    |                                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/25/82 to 10/25/82 that (I) (we) lost<br>saw the deceased alive on 10/25/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                                                              |                                                                                                                                    |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                  |
| 22b. SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                    | DEGREE<br>[Signature]                                                                                                                                       |                                                                                                 | 22c. DATE SIGNED<br>10/26/82                                                         |                                                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marcelino D. Albuerne, M.D.                                                                                                                                                                                                                                                                                                                      |                                                                                                                                    | 22e. ADDRESS<br>5772 Westview Mall, Baltimore, Md                                                                                                           |                                                                                                 |                                                                                      |                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Entombment                                                                                                                                                                                                                                                                                                                                |                                                                                                                                    | 23b. DATE<br>Oct. 27, 1987                                                                                                                                  |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Mausoleum                        |                                                                  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Balto., Md.                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                             |                                                                                                 |                                                                                      |                                                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204                                                                                                                                                                                                                                                                                                          |                                                                                                                                    | ADDRESS<br>1050 York Road                                                                                                                                   |                                                                                                 | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1987                                         |                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                   |                                                                                                 |                                                                                      |                                                                  |

070100 OCT 20 83

Page 1 of 1

Subject: [illegible]

Reference: [illegible]

Date: [illegible]

Personal and Confidential  
Information  
[illegible]

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BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 15, any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                            |                                                                                                                               |                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| FOR<br>STATE<br>REGISTRAR                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                             |                                                                        |                                                                                                                                                             | REG. NO.                                                                                                                                             |                                                                                      |                            |                                                                                                                               |                                                            |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Janet F. Wooden                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             |                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-19-87                                                                                                      |                                                                                      |                            | 2b. HOUR<br>M                                                                                                                 |                                                            |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>White                                                                                                            |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4-22-35                                                                                                               |                                                                                                                                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS                                            |                            | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                     |                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                      |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |                            |                                                                                                                               |                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>17 BELINDA AVE |                                                                        |                                                                                                                                                             |                                                                                                                                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cafeteria        |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>Perry Hall                                                                               |                                                            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                             |                                                                        |                                                                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                                                                      |                            |                                                                                                                               |                                                            |
| 13a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br>Baltimore                                                                                                    |                                                                        | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |                                                                                                                                                      | 13e. STREET ADDRESS / ZIP CODE<br>Senior H.School<br>17 BELINDA AVE.-21206           |                            |                                                                                                                               |                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Houston Simmons                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                             |                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Irene Swecker                                                                                       |                                                                                      |                            |                                                                                                                               |                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-30-2895                                                      |                                                                        | 17. INFORMANT<br>ADDRESS<br>Lester F. Wooden - 17 BELINDA AVE.-21206                                                                                        |                                                                                                                                                      |                                                                                      |                            |                                                                                                                               |                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Small cell lung cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                            |                                                                                                                               | APPROPRIATE INTERVAL<br>BETWEEN DEATH AND DEATH<br>~ 1 yr. |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                             |                                                                                                                                                      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                  |  |                                                                                                                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                                                       |                                                                                      |                            |                                                                                                                               |                                                            |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT HOME AT WORK                                                                                                                                                                                                                                                                                              |  |                                                                                                                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                                                                                    |                                                                                      |                            |                                                                                                                               |                                                            |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>Sept. 22</u> 19 <u>87</u> to <u>October 19</u> 19 <u>87</u> that (i) I saw the deceased alive on <u>Sept. 22</u> 19 <u>87</u> and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (If I did not see the body after death, so state.)                                         |  |                                                                                                                             |                                                                        |                                                                                                                                                             |                                                                                                                                                      |                                                                                      |                            |                                                                                                                               |                                                            |
| 22b. SIGNATURE<br><u>Paul Chang, MD</u>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                             |                                                                        |                                                                                                                                                             | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                                                                      |                            | 22c. DATE SIGNED<br>10/20/87                                                                                                  |                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Paul Chang, MD</u>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                             |                                                                        |                                                                                                                                                             | 22e. ADDRESS<br><u>5601 Loch Raven Blvd, Balto, Md. 21234</u>                                                                                        |                                                                                      |                            |                                                                                                                               |                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>10-23-87                                                                                                       |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem.                                                                                                 |                                                                                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                     |                            |                                                                                                                               |                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>John C. Miller, Inc.-6415 Belair Rd.-21206                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                             |                                                                        |                                                                                                                                                             | 25a. DATE REC'D BY REGISTRAR<br>OCT 24 1987                                                                                                          |                                                                                      | 25b. REGISTRAR'S SIGNATURE |                                                                                                                               |                                                            |

The following is a list of the names of the persons who have been  
 named in the report of the Committee on the subject of the  
 proposed amendment to the Constitution of the United States.  
 The names are given in alphabetical order, and are followed by the  
 number of the page on which they are mentioned.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                   |                                    |                                                                                                                                           |                                                                                                                                                             |                                            |                                                                                                 |                                                                                      |                                                             |                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DOROTHY DuFLON WOODYEAR                                                                                                                                                                                                                                                                                                    |                                    |                                                                                                                                           | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/29/87                                                                                                             |                                            |                                                                                                 | 2b. HOUR<br>2:15 PM                                                                  |                                                             |                                                                                                                                       |
| 3. SEX<br>F                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br>W                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 2, 1911                                                                                        |                                                                                                                                                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS. |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS                                                       |                                                             | IF UNDER 24 HRS<br>HOURS MIN.                                                                                                         |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>NY                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br>US |                                                                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO COUNTY MD.                                        |                                                                                      |                                                             |                                                                                                                                       |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                                               |                                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTO MEDICAL CENTER |                                                                                                                                                             |                                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home               |                                                                                                                                       |
| 13a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                  |                                    |                                                                                                                                           | 13b. CITY OR TOWN<br>A.A.                                                                                                                                   |                                            | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                      | 13d. STREET ADDRESS / ZIP CODE<br>2804 Carrollton Rd. 21403 |                                                                                                                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thaddeus A. V. DuFlon                                                                                                                                                                                                                                                                                                   |                                    |                                                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edith Albert                                                                                               |                                            |                                                                                                 |                                                                                      |                                                             |                                                                                                                                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No                                                                                                                                                                                                                                                                                        |                                    |                                                                                                                                           | 16b. SOCIAL SECURITY NO.<br>043 16 5348                                                                                                                     |                                            | 17. INFORMANT ADDRESS<br>Eugene Creed, Balto., MD                                               |                                                                                      |                                                             |                                                                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic breast carcinoma to lungs & liver<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                    |                                                                                                                                           |                                                                                                                                                             |                                            |                                                                                                 |                                                                                      |                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>                                                                                                                                                                                                                              |                                    |                                                                                                                                           |                                                                                                                                                             |                                            |                                                                                                 |                                                                                      |                                                             |                                                                                                                                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                            |                                    |                                                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                             | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                          |                                    |                                                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |                                                                                      |                                                             |                                                                                                                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                      |                                    |                                                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                      |                                                             |                                                                                                                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/14, 19 87, to 10/29, 19 87, that (I) (we) last saw the deceased alive on 10/29, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                             |                                    |                                                                                                                                           |                                                                                                                                                             |                                            |                                                                                                 |                                                                                      |                                                             |                                                                                                                                       |
| 22b. SIGNATURE<br>Rudiger Breiteneker, M.D.                                                                                                                                                                                                                                                                                                                       |                                    |                                                                                                                                           | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                            |                                                                                                 | 22c. DATE SIGNED<br>10/30/87                                                         |                                                             |                                                                                                                                       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                             |                                    |                                                                                                                                           | 22e. ADDRESS<br>6701 N. Charles St, Towson, Md. 21204                                                                                                       |                                            |                                                                                                 |                                                                                      |                                                             |                                                                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                                                                                                                                                                                                                                                                                                         |                                    |                                                                                                                                           | 23b. DATE<br>10/31/87                                                                                                                                       |                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount                                               |                                                                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD    |                                                                                                                                       |
| 24. FUNERAL DIRECTOR<br>NAME<br>H.W. Jenkins & Sons Co.                                                                                                                                                                                                                                                                                                           |                                    |                                                                                                                                           |                                                                                                                                                             |                                            | 25a. DATE REC'D. BY REGISTRAR<br>NOV 3 1987                                                     |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br>J. S. ...                     |                                                                                                                                       |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove causes of death from pages 1 and 2 and attach them to the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV 2 1961

NOV 2 1961

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NOV 2 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |                                                                        |                                                                                                                                                                        |                                                                       |                                                                                                 |  |                                                                                                                            |                                   | 8 7 2 8 3 5 0                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------|--|
| FOR STATE REGISTRAR                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |                                                                        |                                                                                                                                                                        |                                                                       |                                                                                                 |  |                                                                                                                            |                                   | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William A. Worthman                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |                                                                        |                                                                                                                                                                        |                                                                       | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 1, 1987                                             |  |                                                                                                                            | 2b. HOUR<br>M                     |                                              |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br>White                                                                                                                   |                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 6 03                                                                                                                           |                                                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS                                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                             |                                   | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                             |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |                                                                                                                            |                                   |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8 Pavia Court Apt. 3B |                                                                        |                                                                                                                                                                        |                                                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Grocer-Self Employed        |  |                                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |
| 13a. STATE<br>MD.                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br>Baltimore                                                                                                           |                                                                        | 13c. CITY OR TOWN<br>Rossville                                                                                                                                         |                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>8 Pavia Ct. Apt. 3B 21237                                                                |                                   |                                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Worthman                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |                                                                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine E. Scheidigger                                                                                              |                                                                       |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |                                                                        | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-09-9225                                                                                                 |                                                                       | 17. INFORMANT<br>ADDRESS<br>Mary E. Hildebrand 8 Pavia Ct. 21237                                |  |                                                                                                                            |                                   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE 1a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASHD + CHF</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause lost. |  |                                                                                                                                    |                                                                        |                                                                                                                                                                        |                                                                       |                                                                                                 |  |                                                                                                                            |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>Carcinoma of the Prostate &amp; lower UT obstruction</u>                                                                                                                                                                            |  |                                                                                                                                    |                                                                        |                                                                                                                                                                        |                                                                       |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |                                                                                                                                                                        |                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                   |  |                                                                                                                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |                                                                                                                                                                        |                                                                       | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |                                                                                                                            |                                   |                                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                               |  |                                                                                                                                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                                                                                                                                                        |                                                                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |  |                                                                                                                            |                                   |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                             |  |                                                                                                                                    |                                                                        |                                                                                                                                                                        |                                                                       |                                                                                                 |  |                                                                                                                            |                                   |                                              |  |
| 22b. SIGNATURE<br><u>Aledize</u>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                    |                                                                        |                                                                                                                                                                        |                                                                       | DEGREE<br><u>MD</u>                                                                             |  |                                                                                                                            | 22c. DATE SIGNED<br>10/2/87       |                                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CAESAR C. SHEDJAC                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                    |                                                                        |                                                                                                                                                                        |                                                                       | 22e. ADDRESS<br>201 E. UNIV. PKWY BELT RD 21218                                                 |  |                                                                                                                            |                                   |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    | 23b. DATE<br>10-5-87                                                   |                                                                                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Belair Memorial Gsrdens Bel Air |                                                                                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Harford Md.                                                                  |                                   |                                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>John C. Miller, Inc.-6415 Belair Rd.-21206                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |                                                                        |                                                                                                                                                                        |                                                                       | 25a. DATE REC'D. BY REGISTRAR<br>OCT 06 1987                                                    |  | 25b. REGISTRAR'S SIGNATURE<br><u>John C. Miller</u>                                                                        |                                   |                                              |  |





070455 NOV-28

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                         |                                                                                                                                                             |                                                                                          |                                                                                |                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Joseph E. Yazvac                                                                                                                                                                                                                                                                                                      |                                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 25, 1987                                  |                                                                                | 2b. HOUR<br>11:30 PM                                                                                                       |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                    | 4. RACE<br>White                                                                                                                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 3, 1945                                                                                                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>42 YRS.                                               | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                              | 8. IF UNDER 24 HRS.<br>HOURS MIN.                                                                                          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                                                                                                                                                                                                                                                                                                             | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                             |                                                                                |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7627 Old Battle Grove Road |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Welder - B&S Welding | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                                                                                                                            |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         |                                                                                                                                                             | 13b. COUNTY<br>Baltimore                                                                 | 13c. CITY OR TOWN<br>Baltimore                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas H. Yazvac                                                                                                                                                                                                                                                                                                                        |                                                                                                                                         |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Madge L. Keister                        |                                                                                |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes                                                                                                                                                                                                                                                                                                       |                                                                                                                                         | 16b. SOCIAL SECURITY NO.<br>Vietnam 212-48-3113                                                                                                             | 17. INFORMANT<br>ADDRESS<br>Betty L. Yazvac 7627 Old Battle Grove Road                   |                                                                                |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>GLIOBLASTOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.     |                                                                                                                                         |                                                                                                                                                             |                                                                                          |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                                                                             |                                                                                                                                         |                                                                                                                                                             |                                                                                          |                                                                                |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                          |                                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                       |                                                                                                                                         | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)                                                                                         |                                                                                          | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 1</u> , 19 <u>87</u> , to <u>OCT. 25</u> , 19 <u>87</u> , that (I) (we) lost<br>saw the deceased alive on <u>OCT. 25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                                                                                                                         |                                                                                                                                                             |                                                                                          |                                                                                |                                                                                                                            |
| 22b. SIGNATURE<br><u>L. M. JUMANOV, M.D.</u>                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                         | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                                                                          | 22c. DATE SIGNED                                                               |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. M. JUMANOV, M.D.                                                                                                                                                                                                                                                                                                                      |                                                                                                                                         | 22e. ADDRESS<br>100 N. BROADWAY, BALTO. MD. 21231                                                                                                           |                                                                                          |                                                                                |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                                                            | 23b. DATE<br>10-29-87                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn                                                                                                              |                                                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland               |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck Funeral Home of Dundalk                                                                                                                                                                                                                                                                                                                 |                                                                                                                                         | 25a. DATE REC'D. BY REGISTRAR<br>OCT 30 1987                                                                                                                |                                                                                          | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Ann Ruck</u>                            |                                                                                                                            |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1b above, injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed with this certificate.

070430-24

OCT 30 1954

069806 OCT 27 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |        |                                                                                |                                                          |                                            |                                                                |      |                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------|------|----------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | FIRST                                                                                                                                                       | MIDDLE | LAST                                                                           | 2a. DATE OF DEATH                                        | MONTH                                      | DAY                                                            | YEAR | 2b. HOUR                                                                   |
| MALCOLM                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |        | SAKAGAWA YEAKLE                                                                | 10                                                       | -10-                                       | 87                                                             |      | 14 20 M                                                                    |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                             | 4. RACE                                                                                                   | 5. DATE OF BIRTH                                                                                                                                            |        | 6. AGE (IN YEARS LAST BIRTHDAY)                                                | IF UNDER 1 YEAR                                          |                                            | IF UNDER 24 HRS                                                |      |                                                                            |
| MALF                                                                                                                                                                                                                                                                                                                                                                                               | CAUCASIAN                                                                                                 | 1 - 8 - 91                                                                                                                                                  |        | 96                                                                             | MONTHS DAYS                                              |                                            | HOURS MIN.                                                     |      |                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                                                                                                                                                                                                                                                                                                                                          | 7b. CITIZEN OF WHAT COUNTRY?                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                                           |                                                          |                                            |                                                                |      |                                                                            |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                           | U. S. A.                                                                                                  |                                                                                                                                                             |        | BALTIMORE COUNTY MD.                                                           |                                                          |                                            |                                                                |      |                                                                            |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                                                                                                                                             |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |                                                          | 12b. KIND OF BUSINESS OR INDUSTRY          |                                                                |      |                                                                            |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                          | BALTIMORE COUNTY GENERAL HOSP                                                                             |                                                                                                                                                             |        | ACCOUNTANT                                                                     |                                                          | ACCOUNTING                                 |                                                                |      |                                                                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                                                                                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |        |                                                                                | 13b. STREET ADDRESS / ZIP CODE                           |                                            |                                                                |      |                                                                            |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                             |        |                                                                                | 7159 FAIRBROOK ROAD 21207                                |                                            |                                                                |      |                                                                            |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |        |                                                                                | 15. MOTHER'S MAIDEN NAME                                 |                                            |                                                                |      |                                                                            |
| FIRST MIDDLE LAST                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |        |                                                                                | FIRST MIDDLE LAST                                        |                                            |                                                                |      |                                                                            |
| SOLOMAN H. YEAKLE                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |        |                                                                                | LILLIAN SHANK                                            |                                            |                                                                |      |                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                                                                                                                                                                                                                                                                                                                               |                                                                                                           | 16b. SOCIAL SECURITY NO.                                                                                                                                    |        | 17. INFORMANT ADDRESS                                                          |                                                          |                                            |                                                                |      |                                                                            |
| No.                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           | 214-09-1373                                                                                                                                                 |        | CATHRYN M. FEATHER SAME AS 13                                                  |                                                          |                                            |                                                                |      |                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u><br>888<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                                                           |                                                                                                                                                             |        |                                                                                |                                                          |                                            |                                                                |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>min</u><br><u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><u>recent head injury (fell in NH)</u>                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |        |                                                                                |                                                          |                                            |                                                                |      |                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |        |                                                                                | 20a. AUTOPSY?                                            |                                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |      |                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |        |                                                                                | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                            | YES <input type="checkbox"/> NO <input type="checkbox"/>       |      |                                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                            |                                                                                                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |                                                          |                                            |                                                                |      |                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                       |                                                                                                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                                          |                                            |                                                                |      |                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>87</u> , to <u>10/10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>10/10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |                                                                                                           |                                                                                                                                                             |        |                                                                                |                                                          |                                            |                                                                |      |                                                                            |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |        | DEGREE                                                                         |                                                          | 22c. DATE SIGNED                           |                                                                |      |                                                                            |
| <u>M. MACIULIS</u>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |        |                                                                                |                                                          | 10/10/87                                   |                                                                |      |                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           |                                                                                                                                                             |        | 22e. ADDRESS                                                                   |                                                          |                                            |                                                                |      |                                                                            |
| M. MACIULIS                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |        |                                                                                |                                                          |                                            |                                                                |      |                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | 23b. DATE                                                                                                                                                   |        | 23c. NAME OF CEMETERY OR CREMATORY                                             |                                                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |                                                                |      |                                                                            |
| ENTOMBMENT                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                           | 10-13-87                                                                                                                                                    |        | ROSE HILL CEMETERY                                                             |                                                          | HAGERSTOWN WASH. MD.                       |                                                                |      |                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                           | 305 NORTH POTOMAC STREET<br>HAGERSTOWN, MARYLAND                                                                                                            |        | 25a. RECEIVED BY REGISTRAR                                                     |                                                          | 25b. REGISTRAR'S SIGNATURE                 |                                                                |      |                                                                            |
| GERALD N. MINNICH                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |        | OCT 20 1987                                                                    |                                                          | <u>[Signature]</u>                         |                                                                |      |                                                                            |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23a marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified to give

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)



DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabloids. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

000000 OCT 1957

Subject: [illegible]

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

067669 OCT-67

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

28354  
REG. NO.

|                                                                                         |  |                                                                                                                                             |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                        |  |
|-----------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RICHARD W. ZAPF             |  |                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 2 87 |                                                                                                                                                             |  | 2b. HOUR<br>3 A.M.                                                                              |  |                                                                        |  |
| 3. SEX<br>MALE                                                                          |  | 4. RACE<br>WHITE                                                                                                                            |                                                | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 9 1914                                                                                                              |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.                                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                      |                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |                                                                        |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE                                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>13 MAPLE AVE. CATONSVILLE, MD. |                                                |                                                                                                                                                             |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALESMAN                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>PRINTING                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |                                                                                                                                             |                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                        |  |
| 13a. STATE<br>MARYLAND                                                                  |  | 13b. COUNTY<br>BALTIMORE                                                                                                                    |                                                | 13c. CITY OR TOWN<br>CATONSVILLE                                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>13 MAPLE AVE. CATONSVILLE, MD. 21228 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN ZAPF                                     |  |                                                                                                                                             |                                                | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EVELYN B. DEFFINBAUGH                                                                                      |  |                                                                                                 |  |                                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-05-7128                                                                      |                                                | 17. INFORMANT<br>ADDRESS<br>BARBARA McCLANAHAN 13 MAPLE AVE. CATONSVILLE MARYLAND 21228                                                                     |  |                                                                                                 |  |                                                                        |  |

|                                                                                                                                                                                                                                                                            |  |                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u><br><u>10 months</u> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____                                                                                                                                                                                         |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                                                                        |  |                                                                                      |  |                                                                                                                            |  |
| 22b. SIGNATURE<br><u>J. Cole, M.D.</u> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                                                                                                                                    |  |                                                                        |  |                                                                                      |  | 22c. DATE SIGNED                                                                                                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. JEFFERY COLE                                                                                                                                                                                                                                                                      |  |                                                                        |  | 22e. ADDRESS<br>3455 WILKENS AVE. SUITE 208 BALTO. MD.                               |  |                                                                                                                            |  |

|                                                                                                                    |  |                       |  |                                                            |  |                                                              |  |
|--------------------------------------------------------------------------------------------------------------------|--|-----------------------|--|------------------------------------------------------------|--|--------------------------------------------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL                                                                |  | 23b. DATE<br>10/05/87 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>DRUID RIDGE CEMETERY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PIKESVILLE MD. |  |
| 24. FUNERAL DIRECTOR'S NAME<br>1030 EDMODSON AVE CATONSVILLE MD 21228<br>LEROY M. & RUSSELL C. WITZKE FUNERAL HOME |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 05 1987               |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>             |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84 (VRA 15, 4)

081000 OCT-84

081000 OCT-84

081000

081000 OCT-84

081000



068087 OCT 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28355

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                      |                                                                                                                                                          |                                                                                            |                                                                                                 |                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE B. ZARAFONETIS</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 1 87</b>                                                                                                    |                                                                                            | 2b. HOUR<br><b>2:30P</b>                                                                        |                                                            |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br><b>White</b>                                                                                                                              | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 15, 1903</b>                                                                                             |                                                                                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS                                                |                                                            |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Greece</b>                                                                                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                        | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Baynesville</b>                                                                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LOCH RAVEN HERIDIAN NURSING HOME</b> |                                                                                                                                                          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired - Sales</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Lexington Mkt.</b> |
| 13a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                      | 13b. COUNTY<br><b>Baltimore</b>                                                                                                                          | 13c. CITY OR TOWN<br><b>Parkville</b>                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Basil G. Zarafonitis</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Stavropoulos</b>                                                                                |                                                                                            | 13e. STREET ADDRESS / ZIP CODE<br><b>3500 Hiss Ave. 21234</b>                                   |                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                      | 16b. SOCIAL SECURITY NO.<br><b>213-03-6640A</b>                                                                                                          |                                                                                            | 17. INFORMANT<br>ADDRESS<br><b>Jean Zarafonitis - same as #13e</b>                              |                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probably Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebro Vascular accident</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                                                                                                                      |                                                                                                                                                          |                                                                                            |                                                                                                 |                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                      |                                                                                                                                                          |                                                                                            |                                                                                                 |                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                       |                                                                                                                                                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                               |                                                                                            | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                   |                                                                                            | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-30</b> 19 <b>87</b> , to <b>10-1</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>10-1</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                   |                                                                                                                                                      |                                                                                                                                                          |                                                                                            |                                                                                                 |                                                            |
| 22b. SIGNATURE<br><b>Guineah Tripananeni</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                      | DEGREE<br><b>K.D.</b>                                                                                                                                    |                                                                                            | 22c. DATE SIGNED                                                                                |                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SIREESH K. TRIPURANENI</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                      | 22e. ADDRESS<br><b>Good SAHARITAN HOSPITAL</b>                                                                                                           |                                                                                            |                                                                                                 |                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                      | 23b. DATE<br><b>10-5-87</b>                                                                                                                              |                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greek Orthodox Cem.</b>                                |                                                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                      | 23e. DATE RECD. BY REGISTRAR                                                                                                                             |                                                                                            |                                                                                                 |                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.,</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                      | 1050 York Rd.<br>ADDRESS<br><b>Towson, Md. 21204</b>                                                                                                     |                                                                                            | 25. DATE RECD. BY REGISTRAR<br><b>OCT 06 1987</b>                                               |                                                            |
| 26. REGISTRAR'S SIGNATURE<br><b>W. W. R. R. R.</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                      | 27. REGISTRAR'S SIGNATURE<br><b>W. W. R. R. R.</b>                                                                                                       |                                                                                            |                                                                                                 |                                                            |

BP

Office Memorandum

TO : Mr. [Name]

FROM : Mr. [Name]

SUBJECT : [Subject]

DATE : [Date]

1. [Text]

2. [Text]

3. [Text]

4. [Text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 30 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

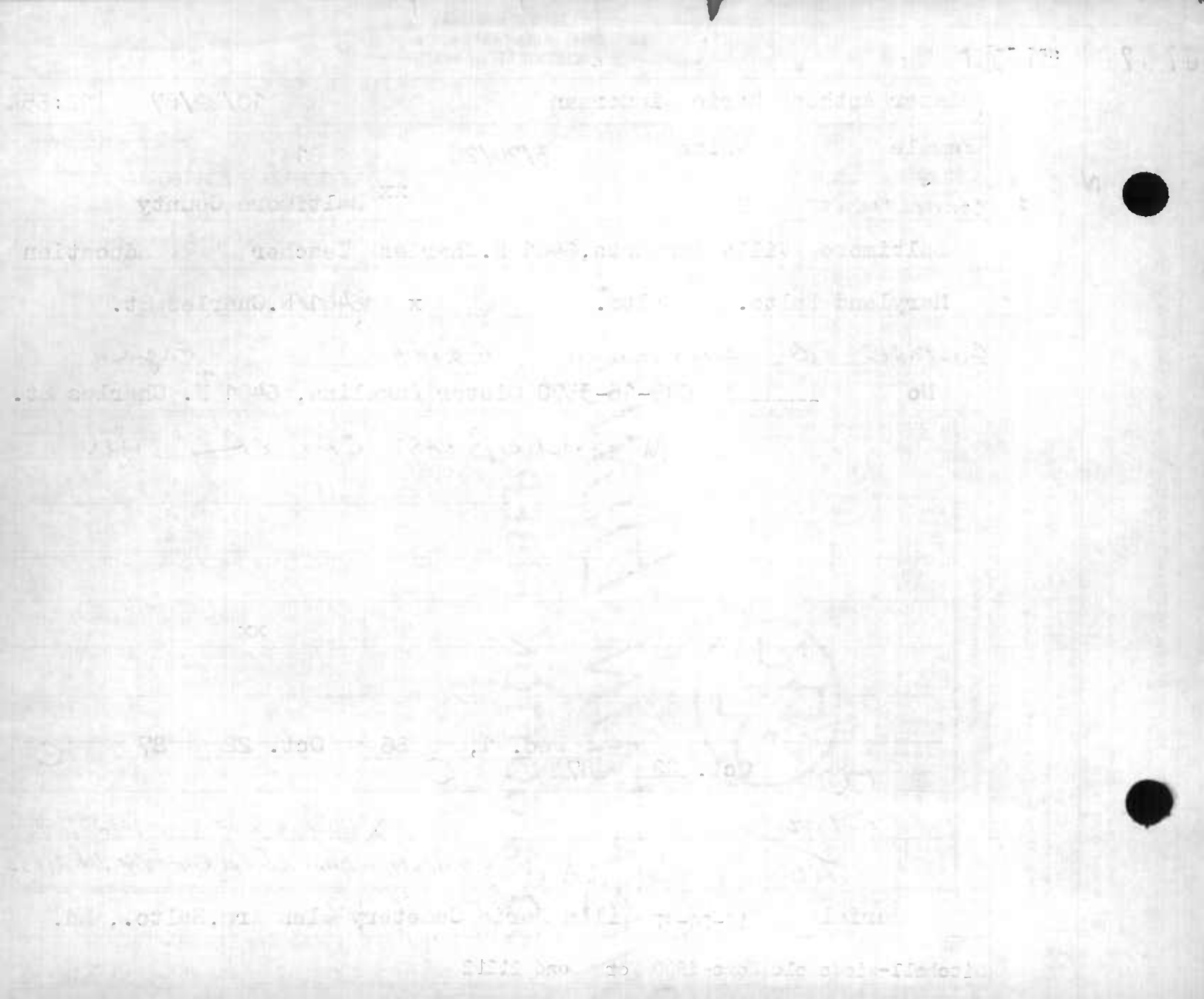
DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |                                                 |                                                                                                                                                             |                         |                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>(Sister) Anthony Marie Zimmerman                                                                                                                                                                                                                                     |  |                                                                                                                                              | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/22/87 |                                                                                                                                                             | 2b. HOUR<br>12:35A<br>M |                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                              |  | 4. RACE<br>White                                                                                                                             |                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3/20/26                                                                                                               |                         | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61<br>YRS                                   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                  |  | IF UNDER 24 HRS<br>HOURS MIN.                                                                                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Connecticut                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                          |                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                   |  |                                                                                                 |  |                                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Villa Assumpta, 6401 N. Charles |                                                 |                                                                                                                                                             |                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Education                                                  |  |                                                                                                                            |  |
| 13a. STATE<br>Maryland                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |                                                 | 13b. COUNTY<br>Balto.                                                                                                                                       |                         | 13c. CITY OR TOWN<br>Balto.                                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>6401 N. Charles St. 21212                                                                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gustave O. Zimmerman                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Grace Fagan                                                                                                |                         |                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, N/A OR UNKNOWN)<br>No                                                                                                                                                                                                                                   |  |                                                                                                                                              |                                                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>049-16-5370                                                                                      |                         | 17. INFORMANT<br>ADDRESS<br>Sister Angelina, 6401 N. Charles St.               |  |                                                                                                 |  |                                                                                                                            |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic BREAST CANCER                                                                                                                                                      |  |                                                                                                                                              |                                                 |                                                                                                                                                             |                         |                                                                                |  |                                                                                                 |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3 yrs                                                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>} DUE TO, OR AS A CONSEQUENCE OF (b)<br>} DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                 |  |                                                                                                                                              |                                                 |                                                                                                                                                             |                         |                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)                                                                                                                                                                           |  |                                                                                                                                              |                                                 |                                                                                                                                                             |                         |                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                         |                                                                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                      |  |                                                                                                                                              |                                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                                                                                                 |  |                                                                                                                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                     |  |                                                                                                                                              |                                                 | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                         | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                                                                                                 |  |                                                                                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1986 to Oct. 22, 1987, that (I) (we) last saw the deceased live on Oct. 22, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |                                                                                                                                              |                                                 |                                                                                                                                                             |                         |                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 22b. SIGNATURE<br>Lawrence Boas MD                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |                                                 | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                         |                                                                                |  | 22c. DATE SIGNED<br>10/22/87                                                                    |  |                                                                                                                            |  |
| 22d. PHYSICIAN'S NAME (PRINT)<br>Lawrence Boas MD                                                                                                                                                                                                                                                             |  |                                                                                                                                              |                                                 | 22e. ADDRESS<br>54 Scott Adam Rd Cockeysville Md 21030                                                                                                      |                         |                                                                                |  |                                                                                                 |  |                                                                                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                                                                                                                                                                                                                                                           |  |                                                                                                                                              |                                                 | 23b. DATE<br>10-24-87                                                                                                                                       |                         | 23c. NAME OF CEMETERY OR CREMATORY<br>Villa Maria Cemetery                     |  | 23d. LOCATION<br>PHYSICIAN TOWN COUNTY STATE<br>Glen Arm, Balto., Md.                           |  |                                                                                                                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home 6500 York Road 21212                                                                                                                                                                                                                                  |  |                                                                                                                                              |                                                 |                                                                                                                                                             |                         | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1987                                   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                                       |  |                                                                                                                            |  |



070567 NOV 30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28357

|                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                  |                                                                                                                                                             |                                                                                   |                                                                                                 |                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Marie J Zingarelli                                                                                                                                                                                                                                                                  |                                                                                                                                  |                                                                                                                                                             | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 29 87                                   |                                                                                                 | 2b. HOUR<br>5:50 P.M.                                                                                                      |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                | 4. RACE<br>White                                                                                                                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12/10/24                                                                                                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.                                        | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |                                                                                                                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND                                                                                                                                                                                                                                                                                           | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD                       |                                                                                                 |                                                                                                                            |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |                                                                                                                                                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>homemaker and |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>catering                                                                              |
| 13a. USUAL RESIDENCE (IF HAVING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND                                                                                                                                                                                                                           |                                                                                                                                  | 13b. COUNTY<br>BALTIMORE                                                                                                                                    | 13c. CITY OR TOWN<br>BALTIMORE                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>218 S. BOULDIN ST. 21224                                                                 |
| FATHER'S NAME<br>FIRST MIDDLE LAST<br>Angelo Manzari                                                                                                                                                                                                                                                                                            |                                                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary RE                                                                                                    |                                                                                   |                                                                                                 |                                                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                                                                                                                                                                                                                                                                      |                                                                                                                                  | 16b. SOCIAL SECURITY NO.<br>220-14-3090                                                                                                                     |                                                                                   | 17. INFORMANT<br>ADDRESS<br>Anthony Zingarelli, 3722 Oakfalls Way 21236                         |                                                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Carcinoma of colon with metastases<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |                                                                                                                                  |                                                                                                                                                             |                                                                                   |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                               |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                                                                                                                                                                                                              |                                                                                                                                  |                                                                                                                                                             |                                                                                   |                                                                                                 |                                                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                          |                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                        |                                                                                                                                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                                                                                  |                                                                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                                                                                                                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                       |                                                                                                                                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                                                                      |                                                                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                               |                                                                                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |                                                                                                                                  |                                                                                                                                                             |                                                                                   |                                                                                                 |                                                                                                                            |
| 22b. SIGNATURE<br>Adel S. El-Hennawy                                                                                                                                                                                                                                                                                                            |                                                                                                                                  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                                                                                   | 22c. DATE SIGNED<br>10-29-87                                                                    |                                                                                                                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Adel S. El-Hennawy                                                                                                                                                                                                                                                                                     |                                                                                                                                  | 22e. ADDRESS<br>S J + 1                                                                                                                                     |                                                                                   |                                                                                                 |                                                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                                                                                                                                                                                                                                                                          | 23b. DATE<br>11/2/87                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith                                                                                                      |                                                                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |                                                                                                                            |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph N. Zannino, 263 S. Conkling St.                                                                                                                                                                                                                                                                          |                                                                                                                                  | ADDRESS<br>21224                                                                                                                                            |                                                                                   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 02 1987                                                    | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall                                                                       |

10 x 15 1/2

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